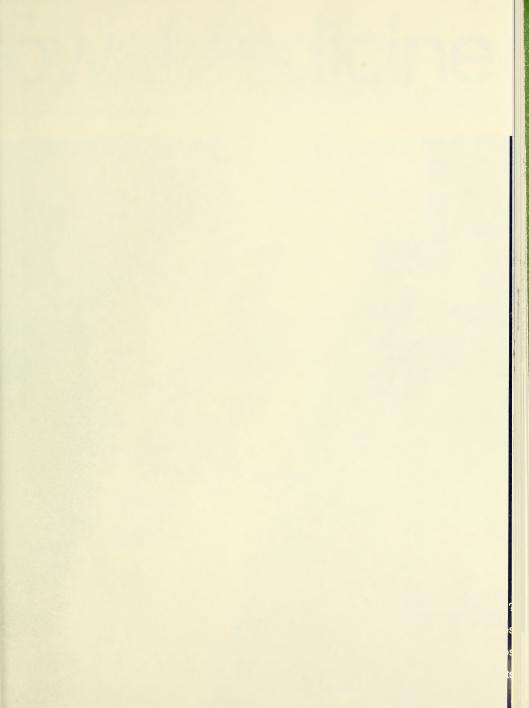
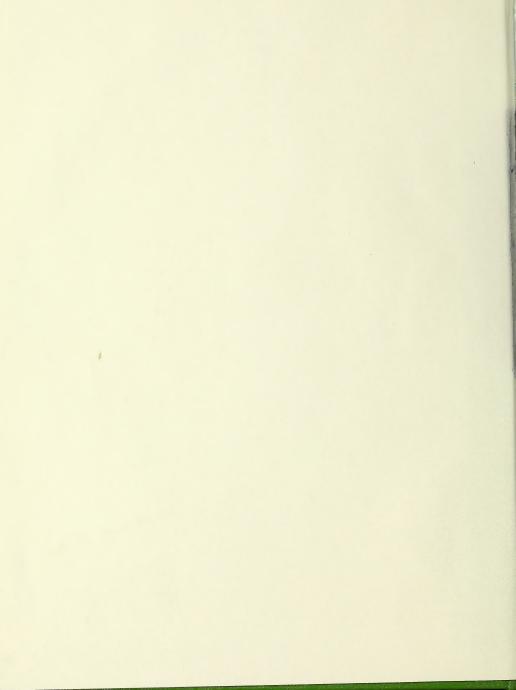


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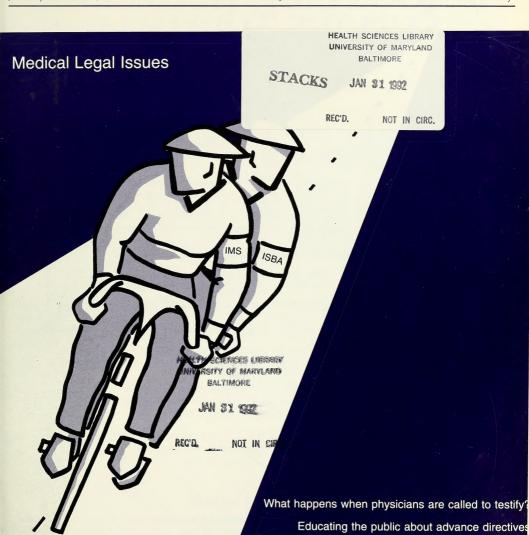
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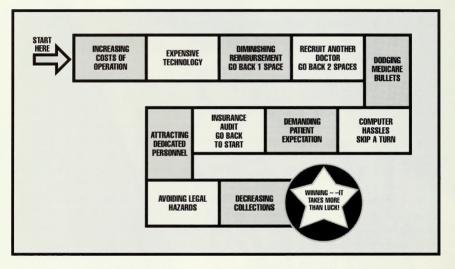
Journal of the Iowa Medical Society

Principles for physician-lawyer relationships

Joint IMS/ISBA projects



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This month's cover sketch symbolizes the cooperative efforts of the IMS and the Iowa State Bar Association in developing public service projects, educational programs and a stronger relationship between the two professions and the two associations. Artwork by Dana Etzel Wharff.

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President's Privilege



R. Bruce Trimble, M.D.

Law and medicine

THE MINISTRY, LAW AND MEDICINE are traditionally considered the learned professions, although perhaps not the oldest. One might think after all these years in leadership positions in society, attorneys and physicians would understand each other better and in-

teract more productively.

On the contrary, as both professions grow in size and importance and as an increasingly complex society forces more frequent contact, we seem in many ways to become more contentious. This January journal—a first-ever issue by the Iowa Medical Society and Iowa State Bar Association—should remind all of us what we share and how much we can do when we join our talents in common cause.

Over the last few years the IMS Medical-Legal Committee, chaired by Warren Wulfekuhler, M.D., has met regularly with the ISBA Health Law Section, chaired by Diane

Kutzko, J.D.

Together, they have:

 Organized annual meetings around the state for physicians and attorneys on legal/ethical aspects of issues such as AIDS and the dying patient. A fourth series is planned for February.

• Revised the "Standards of Practice Governing Physicians and Lawyers" adopted by the ISBA and IMS in 1956. A progress report on this project can be found in this is-

sue.

• Drafted and lobbied for appropriate AIDS legislation and a Durable Power of Attorney for Health Care bill.

• With the Iowa Hospital Association, prepared an excellent patient education pamphlet on advance directives. This project is also discussed elsewhere in this issue.

We look forward to the future activities of the Medical-Legal Committee and the

Health Law Section.

Despite the cooperation, we must acknowledge that medical malpractice continues to be a divisive issue between these two professions. Physicians, like many other groups and individuals, feel the liability system has become dysfunctional, with a societal cost disproportional to societal benefit.

We must also recognize, however, that a malpractice suit originates not with an attorney but with a disgruntled patient; and that many of the excesses of the present system

are rooted in societal attitudes.

Perhaps one day physicians and attorneys will be able to work together on tort reform in the same productive way the ISBA Health Law Section and IMS Medical-Legal Committee have done their exemplary job.

R. Bruce Trimble, M.D. President you are taught to study a problem, form an opinion, express that opinion and defend your position. You see problems as factual, scientifically supported by research and, in a sense, black and white. You are taught to verbalize your reasoning and methodology. It is not your habit to answer a simple "yes" or "no" without supplying reasons for your conclusions.

In the legal process, the questions posed to the expert witness are generally framed for a yes or no response. This dichotomy can be a disaster if you editorialize beyond a simple answer or a tool if you use the simple answer

to challenge your interviewer.

One of my most brilliant colleagues was deposed in his own defense several years ago in a malpractice case. During the deposition, he totally frustrated his own attorney by exposing vital areas of defense strategy. He gave a speech in response to every question and the plaintiffs' attorney reveled in the expanse of information he provided. The defense lawyer lamented, "When they asked him what time it was, he told them how to build a watch!"

Ask your interrogator to rephrase the question until you are able to give a simple yes or no in response. Expound on your opinion only when it is to your advantage. If your questioner asks hypothetical questions that do not pertain to the case, do not give an answer that can be applied out of context to the issues at hand. If you don't understand a question, ask the court reporter to reread it and ask the attorney to clarify the question until you feel comfortable answering.

Watch for questions requiring a "yes" answer being rephrased later in the deposition in such a way as to require a "no" response.

Work within the system

Your role as the expert witness is a responsibility no less important than the care you provided to your patient. Often, your care plan is not complete until you have given necessary testimony to support your patient's claim for damages. You cannot delegate that responsibility to another physician or to the counsel representing the liability insurer. Your patient may only suffer greater losses if that is your attitude.

Physicians have no desire to be involved in the malpractice litigation process. How-

ever, we have a responsibility to speak the truth. Unfortunately, malpractice does occur and competent witnesses are required to sustain legitimate claims for the wrongly treated patient or to speak to the defense of a wrongly accused physician.

You also have a responsibility to help educate the lawyer representing your patient. You should review the patient's records before giving your testimony. You must learn to work within the legal system and cooperate with the responsible attorney who is trying to fulfill his professional responsibilities on difficult medical issues.

More pain than pleasure

In my experience, the pain of being an expert witness usually outweighs the pleasures. I admit, however, that I now feel comfortable performing this role. I know I have rendered an invaluable service to many of my patients when I supported them in their claims for injuries which left them permanently impaired. I have also known the pleasure of testifying for my colleagues unfairly accused of malpractice.

Fortunately, the experience which precipitated my interest in medical-legal issues has not repeated itself, but I know that experience made me a more capable medical wit-

ness.

2. The attorney

What does a trial attorney expect from a medical witness? Dispassionate testimony in terms a lay person can understand, says this lawyer.

H. Richard Smith, J.D.

Des Moines, Iowa

THE NEED FOR MEDICAL EXPERTS arises when someone's mental or physical condition is at issue in a litigated matter. Lawyers tend to place medical experts in 2 categories—trial experts and treating physicians.

Mr. Smith is an attorney with the firm of Ahlers, Cooney, Dorweiler, Haynie, Smith and Allbee, P.C. in Des Moines. He is a past president of the Iowa State Bar Association.

Treating physicians come with the client. The only choice the lawyer has is whether or not to use that physician as a witness. The treating physician does not really have that choice since, under Iowa law, an expert holding opinions needed for the proper resolution of an issue may be compelled to testify.

Physicians have a choice

With regard to trial experts, both the lawyer and the physician have a choice. The lawyer can shop around for a medical expert believed to be the most persuasive on the medical question at issue. However, the physician the lawyer selects does not have to agree to

be a trial expert.

Treating physicians are sometimes in a quandary as to whether they should turn over medical records and discuss a patient's treatment when approached by a lawyer. Most physicians are generally aware of the statutory doctor-patient privilege. What many physicians and lawyers may not realize is that statutory privilege only relates to sworn testimony given at depositions, hearings or trials.

Self-imposed standards

Statutory privilege does not apply to conversations a physician might have with someone outside of a testimonial setting. Any privilege regarding those conversations does not arise from the statute but from the medical profession's self-imposed standards originating in the Hippocratic oath.

Even the statutory privilege relating to the physician's testimony disappears if the patient files an action putting at issue the patient's mental or physical condition. That is the usual type of case in which medical ex-

perts become involved.

The bottom line? In most instances, no statute or law prohibits a lawyer representing a party other than the patient from approaching a physician to discuss a patient's treatment. However, the physician is not required to discuss that treatment with a lawyer and, based on the medical profession's standards of conduct, probably should not without the patient's consent. Most believe the better practice is to obtain a written consent or waiver from the patient before giving medical records to, or discussing treatment with, a lawyer.

Giving medical testimony: current AMA opinion

The AMA's Council on Ethical and Judicial Affairs offers this statement on medical testimony:

"As a citizen and a professional with special training and experience, the physician has an ethical obligation to assist in the administration of justice. If a patient who has a legal claim requests his physician's assistance, the physician should furnish medical evidence, with the patient's consent, in order to secure

the patient's legal rights.

"The medical witness must not become an advocate or a partisan in the legal proceeding. The medical witness should be adequately prepared and should testify honestly and truthfully. The attorney for the party who calls the physician as a witness should be informed of all favorable and unfavorable information developed by the physician's evaluation of the case. It is unethical for a physician to accept compensation that is contingent upon the outcome of litigation."

Retaining a medical witness

The lawyer retains the medical expert on behalf of the client, who is responsible for the expert's fees and expenses. However, the lawyer often advances those fees and expenses to assure the expert is paid.

The terms of retention should be clearly understood by all parties at the outset. This includes fees and expenses, the scope of the expert's assignment, an approximation of the time involved and the expert's availability for deposition and trial testimony.

Preparing the witness

The lawyers' phrase "preparation of witnesses" is frequently misunderstood. Despite

(Continued on next page)

my oft-repeated joke that lawyers simply advise witnesses to tell the truth and then tell them what the truth is, that definitely is not

preparation of witnesses.

Preparing medical witnesses means giving them medical records and other information to help them form opinions. It includes explaining the legal process and preparing them for examination by the adverse party's counsel. It means doing everything necessary to assure the expert's opinions are fairly and persuasively presented.

Frequently, medical witnesses do not take enough time for preparation. The expert may think it unnecessary and a nuisance. However, it is a very important part of the

lawyer's duty to the client.

Discovering information

"Discovery" has a specific technical meaning in trial law. It denotes procedures which allow parties to court actions to obtain information about an adverse party's case. That includes information concerning the identity and opinions of the experts.

Thus, the lawyer must seek, the assistance of the medical expert to respond to discovery requests. If the expert is a treating physician, it will be necessary to compile and produce medical records. Interrogatories will have to be answered identifying the expert and summarizing the expert's trial opinions.

According to recent rule changes, the expert signs the interrogatory answer disclosing expert opinions under penalty of perjury. And, of course, there are the inevitable depo-

sitions of experts.

The court prescribes time schedules for discovery. Recently, those schedules have been expedited. That means the lawyer has limited flexibility to accommodate the medical expert's schedule when expert involvement in the discovery process is required.

Court appearance preferable

Only 5-8% of civil actions filed in Iowa go to trial. For that reason, most experts' testimony will be limited to pretrial depositions. In cases that are tried, it is necessary to schedule a time for the medical expert to appear as a witness.

Many medical experts prefer to give trial testimony by deposition rather than making a

court appearance. For the lawyer and client, however, the medical expert's testimony is of much greater value if given live at trial. Even with video taped depositions, jurors and judges almost always give more attention and consideration to live testimony. The medical expert should therefore expect the lawyer to apply pressure for a court appearance. This should be resolved at the time the expert is retained.

Physicians testifying as medical experts are often perplexed by the lawyer's efforts to obtain certainty in opinions on matters which are medically uncertain. Will the patient endure pain and suffering in the future? Is there a definite answer to that question? God probably has the answer but is beyond the

court's subpoena powers.

The law is of little aid to the physician wondering how to state an opinion. The general rule is opinions must be based on a reasonable degree of medical certainty. Probably no one knows what constitutes a reasonable degree of medical certainty. The courts now permit medical experts to render opinions even though they are not based on a reasonable degree of medical certainty if it achieves that degree of certainty when coupled with lay testimony.

Don't be partisan

Most lawyers do not want doctors to become partisan advocates when they testify. Rather, they want them to express their thoughts and opinions in a dispassionate, professional manner using terms lay people can understand

The fact is, all expert testimony—including medical expert's testimony—seems to be far more important to lawyers and judges than it is to jurors. Studies show most jurors assume litigants can find experts to say almost anything. For that reason, the jurors opinion of a medical expert as a person is probably far more important than what the medical expert actually says.

It is hoped this article will assist physicians, when called upon to be medical witnesses, to better understand what is involved from the lawyer's perspective. By the same token, lawyers need to become better informed about the physicians' point of view. The beneficiaries of this understanding will

be the public.

IMS, ISBA cooperation yields new laws on advance directives

Iowans have greater control over their medical care, thanks to the cooperative efforts of the Iowa State Bar Association and the Iowa Medical Society.

Peter Benson, J.D.
Davenport, Iowa
William Hesson, J.D.
Iowa City, Iowa
Cynthia Moser, J.D.
Sioux City, Iowa

BEFORE 1991, IOWA LAW recognized only one form of advance directive, the Living Will, as a way for someone to express wishes regarding medical treatment in the event the person lost the ability to make health care decisions.

In May of 1991, the Durable Power of Attorney for Health Care statute was signed into law, filling an important gap in the legal framework for decision making at the end of life. The process by which this significant legislation was developed and enacted signals a new spirit of cooperation between the medical and legal professions.

During the fall of 1989, the Health Law Committee of the Iowa State Bar Association (ISBA) discussed the limitations of the Life Sustaining Procedures Act—Iowa's Living Will—and agreed to pursue enactment of companion legislation to create a Durable Power of Attorney for Health Care. A preliminary draft was developed.

Iowa Medical Society joins effort

The Iowa Medical Society (IMS) was also interested in this proposed legislation. As a result of the working relationship between the IMS Medical-Legal Committee and the ISBA's Health Law Section Council, the IMS and the ISBA were able to establish a consensus in support of the draft legislation.

Under the Durable Power of Attorney for Health Care, (usually called Medical Power of Attorney) any person may designate someone to make health care decisions if the person becomes unable to do so. Although this Medical Power of Attorney is usually discussed in the context of decisions to withhold or withdraw treatment, it is not limited to those situations.

Medical power is more flexible

The Medical Power of Attorney has several advantages over the Living Will. First, it is

(Continued on page 43)

Mr. Benson practices with Lane and Waterman in Davenport. Mr. Hesson is senior assistant director, University of Iowa Hospitals and Clinics. Ms. Moser practices in Sioux City with the firm of Berenstein, Vriezelaar, Moore, Moser and Tigges.

more flexible. The Living Will may be used only to indicate the persons's desire that life-sustaining procedures be withheld or with-drawn if the individual has a terminal condition. The Medical Power of Attorney provides a way for someone to direct that specific medical treatments be initiated while others are withheld.

Second, the Medical Power of Attorney allows an individual to designate someone to make decisions any time the individual is unable to make them. The Living Will is effective only when the patient has been diagnosed to be terminally ill.

Finally, the Medical Power of Attorney includes a definition of "health care" which permits an individual to direct his or her representative to consent to withholding or withdrawal of artificial feeding. The Living Will statute specifically excludes the provision of sustenance from the definition of lifesustaining procedures.

Patient brochure developed

After the legislature adopted the Medical Power of Attorney law, representatives of the ISBA and IMS joined forces with the Iowa Hospital Association (IHA) to develop a brochure informing the public about advance directives in Iowa. (See sidebar story for more information.)

The IHA was interested in assisting its member hospitals in implementing obligations under the Patient Self Determination Act adopted by Congress in 1990. Since December 1, all hospitals have been required to provide information on advance directives to all adults admitted as inpatients.

In the past, the ISBA has made Living Will forms available to the public. With adoption of a second advance directive, the ISBA and IMS shared the concern that forms should not be distributed without accompanying information explaining the distinction between the documents and information on how to complete the form.

In the fall of 1991, representatives of the ISBA, IMS and IHA met to develop a draft of a patient brochure explaining advance directives for health care and advising patients about how to obtain forms. The final draft was completed in November and was approved by the Iowa Department of Human Services as in compliance with the Patient Self Determination Act. The Iowa Nursing

Home Association and Iowa Hospice Association have also endorsed the brochure.

Benefits of cooperation

This patient brochure illustrates what can be accomplished through interprofessional cooperation. To recognize this accomplishment, the ISBA has nominated the brochure for a national award sponsored by the American Bar Association Commission on Partnerships. This commission encourages lawyers to cooperate with other professions on matters of public benefit.

The IMS and ISBA continue to work together to draft legislation to resolve problems with Iowa's advance directives and bring them into conformity. Efforts are centered on eliminating certain technical inconsistencies and broadening application of the Living Will by redefining the terms "terminal illness" and "life-sustaining procedure."

The IMS and ISBA have demonstrated an ability to work together toward a common goal, each contributing its special expertise. The result is better than either organization could have achieved on its own.

Interested in ordering brochures?

The brochure produced by the IMS and ISBA is entitled "Advance Directives for Health Care." It explains, in terms lay people can understand, Iowa's Living Will and Medical Power of Attorney laws.

Neither physicians nor attorneys are required by law to provide information on advance directives to their patients/clients. However, your patients/clients may have questions.

Physicians who wish to order copies of the brochure may do so by writing to the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265. The cost of the brochures is \$10 for 100. Physicians should enclose a check made payable to the Iowa Medical Society.

'Code of civility' for attorneys, physicians

Representatives of the ISBA and IMS are working on a modern version of 1956-vintage practice principles governing lawyer-physician relationships.

Diane Kutzko, J.D. James Turner, M.D.

Cedar Rapids, Iowa

THE CONCEPT OF A CODE of understanding between lawyers and physicians is not new in Iowa. In 1956, the Iowa State Bar Association (ISBA) and the Iowa Medical Society (IMS) adopted "Standards of Practice Governing Lawyers and Physicians," which set out guidelines for the day-to-day relationship between physicians and lawyers.

Unfortunately, the 1956 standards were not widely circulated or widely followed, and the relationship between the professions became strained. In the mid-1980s, the ISBA's Outreach to Other Professions Committee, with the cooperation of the IMS, put a great deal of effort into attempting to revive those standards. In addition, there are county-level efforts to formalize guidelines between physicians and lawyers and to arbitrate or mediate fee disputes between the professions.

Over the past year, building on a growing collaboration, the IMS and ISBA have resumed efforts to codify a set of principles, a kind of "code of civility" to promote the interests of patients/clients and minimize day-to-day friction between lawyers and physicians.

Do we need more rules?

The threshold questions must be asked: do we need yet another set of rules to complicate our lives? If so, what form should they take? Will they be of any use if there is no enforcement mechanism?

The answers to these questions remain unclear. However, it is clear that it is essential to the interests of our patient/clients for physicians and lawyers to understand and respect the constraints under which the other profession works. In a perfect world, written guidelines would be unnecessary. However, this is not a perfect world. Physicians are spending less time on patient care, given the need for compliance with federal and state regulations and the demands of third party payors. Litigation-based requests from attorneys create yet one more demand on a physician's time. This is not necessarily the fault of lawyers. The manner in which lawyers seek information from physicians is governed by

Ms. Kutzko is a member of the ISBA's Health Law Committee. Dr. Turner, an orthopedic surgeon, is a member of the IMS Medical-Legal Committee.

(Continued on page 43)

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Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general

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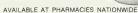
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- 4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



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formal discovery rules, federal and state privacy laws and appellate precedents.

Therefore, the formulation and adherence to guidelines may be useful, particularly as our respective practices become more difficult. In addition, new physicians and lawyers do not have the tradition of mentoring from which earlier generations benefitted.

Seeking your comments

A draft of the new "Principles of Cooperation" follows. This draft is being circulated to physicians and to lawyers in the litigation and health law sections of the Bar.

Several basic concerns are addressed in the guidelines:

- A physician has a duty to assist a patient when the patient seeks legal recourse that requires medical expertise.
- The lawyer (not the patient) has a concomitant duty to compensate the physician fairly, based on the nature of the information provided (e.g., compensation for an opinion concerning prognosis should reflect the time spent; copying costs for medical records may reflect staff time).
- A physician has a duty to provide testimony at trial or by deposition. The physician must realize that an attorney sometimes has no control over delays or postponements. However, an attorney should attempt to give a physician reasonable notice of the need for testimony and of any cancellations or delays that might occur.

Joint ISBA, IMS seminars

In February of 1992, the ISBA and IMS will sponsor the fourth annual joint seminars in Des Moines, Sioux City and Cedar Rapids. The topic will be cooperation between the professions. These will afford an opportunity to explore the need for standards and to discuss areas of friction or conflict. Lawyers from the plaintiff's and defense bars will present, as will physicians from each commu-

The draft of "Principles of Cooperation between Lawyers and Physicians" is printed here. It may not address all your concerns. You are encouraged to send comments concerning the draft to: Diane Kutzko, 500 Firstar Bank Building, P.O. Box 2107, Cedar Rapids, Iowa 52406 or to Tina Preftakes, Iowa Medical Society, 1001 Grand, West Des Moines, Iowa 50265.

Principles of Cooperation Between Lawyers and Physicians

The cooperation of physicians and attorneys in their day-to-day professional dealings is essential to the smooth running of the legal system. It is also in the best interests of the population both professions serve: patients and clients.

As a general proposition, a physician should understand that medical testimony is frequently indispensable to prove or disprove the nature and extent of injuries. Therefore, a physician has a responsibility to cooperate with the patient, the patient's attorney, and opposing counsel, if litigation ensues for recovery of damages for the injuries so sustained. An attorney has the corresponding duty to recognize that a physician providing information or testimony in either a treating or expert capacity should be accommodated to the extent possible and with a minimum of disruption to his or her practice.

(The following is a set of the proposed recommendations and guidelines designed to promote cooperation and avoid conflict between

physicians and attorneys.)

Medical reports

- All requests for medical records and reports by attorneys and furnishing of medical records and reports by physicians should be in compliance with applicable federal and state statutes and rules of civil procedure, case law, and ethical principles of both professions.
- When medical records are requested by the patient's attorney or opposing attorney, the request must be in writing and must be accompanied by a written authorization from the patient. Specific consent must be given for mental health records, drug/alcohol treatment records, and AIDS (HIV)-related records.

Physicians may charge the reasonable cost of providing those records or reports to either the patient's attorney or opposing counsel.

În the case of medical records, the reasonable cost may include copying charges and a charge that reflects office staff time expended in processing the request and making copies.

5. In the case of medical reports, the reasonable cost should include the time spent by the

physician in reviewing the records and formulating an opinion, as well as the time spent in drafting the report.

6. The patient or his or her attorney (as agent) is entitled, upon written request, to a prompt report from the attending or treating physician concerning history, findings, treatment, diagnosis and prognosis.

If a patient's attorney requests medical records or reports, the patient's attorney, and not the patient, should assume the responsibility for payment to the physician.

 All original records of attending physicians made in connection with treatment and care of the patient, including radiographs and reports of diagnostic and therapeutic procedures, are the property of the physician.

Testimony

- 1. The physician has a right to expect reasonable compensation for testimony given as an expert or treating physician either by deposition or in court. It is reasonable that the compensation reflect the time away from medical practice during both preparation for and actual testimony. This is best accomplished by an hourly fee, however, should the physician wish to charge a flat fee, that fee must be based on a reasonable calculation of the overall time it is anticipated the physician will be spending in preparation and testimony.
- Payment of fees for medical testimony shall not be contingent upon the outcome of the litigation.
- Upon reasonable notice, a physician should make himself or herself available for giving of oral testimony, either by deposition or in court
- 4. An attorney should appreciate that a physician has continuing and often unpredictable responsibilities to his or her patients. In so far as he or she is able, the lawyer should make arrangements to permit the physician to testify with a minimum of inconvenience and delay to the physician.

If scheduled medical testimony is canceled, the physician shall be entitled to charge depending on the time of notice and nature of

practice

6. If a subpoena is viewed as necessary or appropriate by the attorney, if practicable, the physician should have reasonable advance notice that a subpoena will be served compelling his or her testimony at some predetermined time and place.

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For coverage information specific to your practice, contact IMS SERVICES, a subsidiary of the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, IA 50265. (515) 223-2816 or (800) 728-5398.



Questions and Answers



Carroll Reasoner, J.D.

An interview with the president of the ISBA

The first woman president of the Iowa State Bar Association says doctors and lawyers have more in common than they might realize.

What do you hope to accomplish as president of the Iowa State Bar Association (ISBA)?

I am the first woman to serve as the ISBA president and my presidency is evidence of the dramatic changes in the demographics of the legal profession. I have worked hard to open the organization and its activities to all members.

An important goal is to promote the continuing efforts and activities of the ISBA in areas of substantive law and public service. The ISBA puts forth legislation to improve our laws, address new issues and serve as a resource to the legislature. Our members are involved in many public service projects including handbooks on legal issues for the elderly and law-related education programs in our schools.

What professional issues are of concern to attorneys right now?

An issue of great concern is inadequate funding of the court system. It is becoming increasingly difficult to get civil issues resolved in the courts because of the dramatic increase in criminal cases. The drug crisis has imposed tremendous burdens on a system that was under-funded to begin with.

Another important issue is insufficient money for legal services for the poor. In addition to efforts to obtain sufficient funding, over half the lawyers in Iowa donate their time to the Volunteer Lawyers Project.

A third concern is the increasing perception that lawyers are somehow responsible for all the ills in this country. I am frustrated with the attack when I know that Iowa lawyers are committed to their clients and communities, have high ethical standards and give many hours in pro bono services.

How would you characterize general relations between lawyers and physicians?

Though I believe this is the first time our organizations have collaborated on our respective publications, our professions have long

(Continued on page 43)

worked hand in hand in serving the public. However, a number of years ago a rift occurred between the IMS and the ISBA over tort reform. Though all differences of opinion on tort reform have not been resolved, the atmosphere has been quieted somewhat by legislative changes advocated by both the IMS and the ISBA. The number of civil cases filed in Iowa is decreasing. The courts are crowded because of an increase in the criminal docket.

However, I must say it is too simplistic to place all the blame for the liability climate at the feet of the legal profession. There cannot be a successful malpractice claim unless another physician is willing to testify that the standard of care was violated.

There may well be truth in Time Magazine's recent proclamation that we have become a nation of cry babies and busy bodies. However, we must remember that lawyers are no more responsible for this attitude than are legislators, judges or juries. To change our litigious society we need to address all components of the issue. Much could be done to smooth the relationship between doctors and lawyers in trial matters.

In spite of tension over tort reform, our professions have recently worked very well together for the benefit of Iowans. We have had joint meetings on AIDS and advance directives. The IMS and ISBA worked together for passage of the Durable Power of Attorney for Health Care decisions. We have collaborated on this month's issues of IOWA MEDICINE and IOWA LAWYER. More joint projects are in the works.

What are the similarities between the medical and legal professions?

Both of our professions are under attack from many directions and many attorneys and physicians are expressing dissatisfaction with their practices. The way we practice has changed and there is demand for our services regardless of ability to pay.

There is tremendous pressure on physicians and attorneys to contain costs while getting the best result. Loyalty to one's physician or attorney has faded. Nonprofessionals want to practice what we do and are obtaining the rights to do so through legislative edict-not training or experience.

rating. Any error in judgment or difference of opinion between our colleagues may be ques-

Our reputation with the public is deteriotioned or pursued.

The challenges facing our professions are huge. However, our professions contain community leaders in most Iowa cities. Together, this leadership can fashion programs to more effectively utilize our resources.

How will physicians and lawyers gain from a good working relationship between our respective professional organizations?

The members of the IMS and the ISBA are Iowa residents and are concerned about our state's development. We both serve the people of Iowa. Advance health care directives and AIDS issues are examples of public health issues where we can work together for positive re-

Lawyers and physicians must be proactive on medical-legal issues. We must work with our legislators to devise legislation in areas such as mental health, child abuse, reimbursement issues, insurance coverage and rights of the disabled.

I am proud of Iowa's physicians and attorneys for their strong commitment to serving Iowans and for striving to maintain our respective professions. With the continuation of cooperative effort, more goals can be reached.

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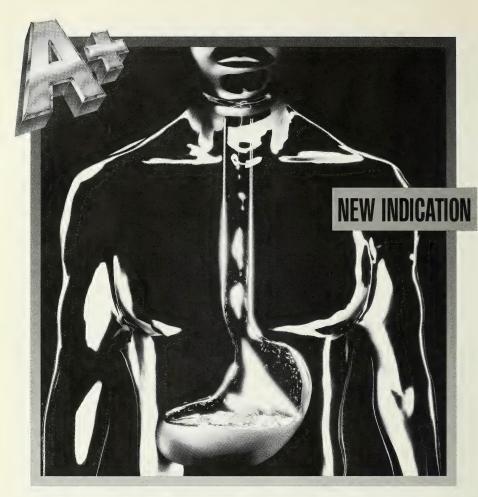
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complete prescribing information.
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3. Gistingenophanial tellul disease (GFRP)—In our
3. Gistingenophanial tellul disease (GFRP)—In our

3. Gastroesophageal reflux disease (GERD)—for up

to 12 weeks of treatment of endoscopically diagnosed esophagitis, including erosive and ulcerative esophagitis, and associated heartburn at a dosage of 150 mg b.i.d. Contraindication: Known hypersensitivity to the drug Because cross sensitivity in this class of compounds has Because cross sensitivity in this crass or compounds has been observed, H₂-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H₂-receptor antagonists. **Precautions**: General—1. Symptomatic response to

of gastric malignancy.

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Laboratory Risks—False-positive lesis for urbinlogne with Multistat," may occur during therapy.

Drug interactions—No interactions have been observed with theophylline, chloridizepookee, foragenyaindicaries, phenylogn, and warfarn. Avid does not inhibit the cytochrome P-50 enzyme system; therefore,
drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given

very high doses (2000 mg) of signin drugs, increased server associated levels were seen when nazidine,

very lying to does 12-sido may of asplant coally, inclusions across a consequence were seen when mutations Carrongments (Middenests, Migraenests, Migraenest), reprinter of Fertilip—A 2-year and accompanishy study in rais with does as high as 500 mg/kg/dky about 80 times the recommended daily therapeutic does abwed no evidence of a carrongment effect. There was a does-related increase in the density of enterchornation-like (ECL) cells in the gastric oxynite mucosa. In a 2-year study in mice, there was no evidence of a carrongment effect in male mice, although hypothesis collected on the liver were increased in the high-dees makes as compared with mice, although hypothesis collected on the liver were increased in the high-dees makes as compared with the control of the co mice, amough hyperposition fooulise or me livet were increased in the high-dose make as compared with packed. Fertiles there were the high dose of Avid (2,000 mg/glies), about 300 times he human dose) showed packed. The packed increase seen in any of the other dose groups. The rate of hepatic carcinoms in the high-dose animals was within the historical control limits seen for the start of mice used. The fertile mice were given a dose larger than the maximum oberated dose, as indicated by excessive (30%) weigh decrement as compared to the concurrence or the control of the dose of the control of the control of a marginal with concurrence profits and evidence of mid-liver limity. (Instantivase developes in the control of a marginal to the control of the control of the control of the control of a marginal to the control of the control of the control of the control of a marginal to the control of the control of the control of the control of a marginal to the control of the con

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Miegumerial— Micraia was reported significantly orifice.

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indiministration "have been reported. Rare exposites of hypersonsivity reactions (op) chrochospora. Inarynadi
idema, rash, and ossinophilia) have been reported.

**Other--hyperurinoria unassociated with opout or rephrolithasis was reported. Eosinophilia, fever, and

nausea related to nizationine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal,

emesis, or lawage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method PV 2093 AMP

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New arrangement for **IOWA MEDICINE** columnists





Richard Caplan, M.D.

Richard Nelson, M.D.

Richard Caplan, M.D., longtime author of the IOWA MEDICINE column "CME Notebook" and associate dean for Continuing Medical Education at the University of Iowa College of Medicine, has taken a new position. Dr. Caplan is now coordinator of the U of I Program in Medical Humanities. Beginning this month, Dr. Caplan has a new IOWA MEDICINE column entitled "The Art of Medicine." This column will be published every other month.

Richard Nelson, M.D., is the new associate dean of CME. He has been an associate professor with the U of I's Department of Pediatrics since 1987 and serves as director of the Statewide Child Health Specialty Clinics. Beginning in February, Dr. Nelson will take over Dr. Caplan's CME column, which has been renamed "The Physician Learner." Dr. Nelson's column will alternate with Dr. Caplan's "The Art of Medicine."

LETTERS TO THE EDITOR

If you have a comment regarding something you've read in IOWA MEDICINE or an observation on conditions affecting the practice of medicine in Iowa, don't keep it to yourself. Share your thoughts in a letter to the editor. We'd like to hear from you.

MERCY HOSPITAL MEDICAL CENTER

DES MOINES, IOWA
PRESENTS

HIV IN IOWA: IMPACT ON THE HEALTH CARE PROVIDER

FEBRUARY 12, 1992

GUEST FACULTY

JACQUELYN POLDER, B.S.M., M.P.H.
CHIEF, GUIDELINES UNIT
AIDS ACTIVITY
HOSPITAL INFECTIONS PROGRAM
CENTERS FOR DISEASE CONTROL
ATLANTA. GEORGIA

FRANK S. RHAME, M.D.
ASSISTANT PROFESSOR
DIVISION OF EPIDEMIOLOGY
SCHOOL OF PUBLIC HEALTH
'JNIVERSITY OF MINNESOTA
MINNEAPOLIS. MINNESOTA

ROBERT L. MURPHY, M.D. CLINICAL COORDINATOR AIDS BIOPSYCHOSOCIAL CENTER NORTHWESTERN UNIVERSITY MEDICAL SCHOOL CHICAGO, ILLINOIS

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TOPICS

"THE MYTHS AND THE FACTS OF HIV RISK TO HEALTH CARE WORKERS"

"MOLECULAR VIROLOGY/IMMUNOLOGY OF HIV INFECTION AND ANTI-RETROVIRAL THERAPY"

"OVERVIEW AND NEW DEVELOPMENTS IN THE EPIDEMIOLOGY AND CLINICAL PRESENTATION OF HIV INFECTION"

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CONTACT: DEPARTMENT OF MEDICAL EDUCATION MERCY HOSPITAL MEDICAL CENTER

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Clinical use of adenosine

Adenosine (Adenocard®) is a new injectable antiarrhythmic agent indicated for the acute treatment of paroxysmal supraventricular tachycardia (PSVT) including PSVT associated with the Wolff-Parkinson-White syndrome. Many physicians are not yet familiar with its actions, indications and side effects.

Douglas Geraets, Pharm.D. Michael Kienzle, M.D.

Iowa City, Iowa

A DENOSINE IS AN ENDOGENOUS adenine nucleoside generated from adenosine triphosphate (ATP), a labile compound which provides the energy for essentially all physiological processes in cells. These include regulation of coronary and systemic vascular tone, platelet function, glycolysis, lipolysis in fat cells and intraatrial conduction. ATP is rapidly hydrolyzed to adenosine monophosphate (AMP), which is further dephosphorylated to adenosine.

Cardiac and hemodynamic effects

Adenosine appears to dilate resistance vessels in all tissues except the hepatic venous system. This includes coronary vasodilation in response to stimuli such as ischemia. Thus, constant intravenous infusions of adenosine pro-

duce coronary and peripheral vasodilation. In contrast, bolus doses (6 to 12 mg) used clinically for arrhythmia indications appear to have negligible effects on systemic hemodynamics. Adenosine produces a negative inotropic effect in both atrial and ventricular myocardium. The negative inotropic effects can be antagonized by xanthines (e.g., theophylline) which competitively block the adenosine receptor but are not affected by atropine.¹

Adenosine has an effect on cardiac rate (chronotropy) via a direct depressant action on the SA node which appears to be mediated via a direct effect on a background K+outward current of myocardial actiles.²³ Most important for its antiarrhythmic activity, adenosine impairs AV nodal conduction (dromotropy) due to a depressant action at the proximal portion of the AV junction.³

However, adenosine does not impair impulse propagation through atrial or ventricular tissue. Its antiarrhythmic effects include a high degree of effectiveness in terminating re-entrant tachycardias involving the AV node. In addition, adenosine has antiadrenergic effects as shown by its ability to antagonize the effects of isoproterenol.⁴

Douglas Geraets is associated with the U. of I. College of Pharmacy. Dr. Kienzle is associated with the U. of I. College of Medicine.

THE IOWA MEDICAL FOUNDATION HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION AWARD FOR JANUARY 1992

Adenosine will also terminate sustained episodes of idiopathic VT noted in some patients without underlying structural heart disease, which are often exercise-related and/or facilitated by infusion of isoproterenol. This type of VT may well have a non-reentry mechanism, such as triggered activity, underlying its occurrence.⁵ In contrast, the common form of VT associated with structural heart disease (usually ischemic) and likely due to a reentry mechanism does not respond to the administration of adenosine.

Respiratory effects

Inhaled adenosine appears to have no affect on bronchial tone in healthy subjects.⁶ However, the administration by inhalation to asthmatic patients causes marked bronchoconstriction lasting up to 30 minutes.⁷

Pharmacokinetics

Adenosine is rapidly removed from plasma via uptake by erythrocytes and removal by vascular endothelial cells. Once intracellular, adenosine is phosphorylated by adenosine kinase to AMP and at high concentrations deaminated (by adenosine deaminase) to inactive inosine. Inosine is further metabolized to hypoxanthine and then to uric acid.

The plasma half-life of adenosine, estimated from *in vitro* studies in human blood, ranges from 0.6 to 10 seconds. An intravenous bolus of adenosine would be completely removed from plasma in approximately 30 to 60 seconds. No adjustment of dose is required in hepatic or renal dysfunction.

Clinical trials

A number of clinical trials have evaluated adenosine in the treatment of supraventricular tachycardia (SVT). Many of the early studies with adenosine involved uncontrolled or retrospective evaluations in small numbers of patients with spontaneous arrhythmias.3,f1,12 Recently, the results of 2 multicenter, randomized, double-blind clinical trials have been published.13 These studies, the basis for FDA approval of the drug, were designed to evaluate the dose response of adenosine in termination of PSVT and to compare its effects with those of verapamil. Since the data from the multicenter studies confirmed previously described efficacy of intravenous adenosine for rapid termination of SVT, this review will focus on the latter investigations.

The first multicenter study was a double-blind comparison of single, sequential IV bolus doses of 3, 6, 9 and 12 mg of adenosine versus placebo (1, 2, 1.5, and 2 mL of normal saline). One hundred seventy-two patients met the entrance requirements and 137 were randomized to adenosine and 64 to placebo (2:1 ratio by study design).

Effects of adenosine were seen at the lowest dose used and increased in stepwise fashion with dosage increase to an efficacy rate of 92% at 12 mg. This is consistent with the 90 to 100% efficacy rates in PSVT reported by other inves-

tigators. 11,12

The second multicenter study included 131 patients with either spontaneous or induced SVT randomized to either adenosine or verapamil.¹³ Adenosine and verapamil were administered in 6 mg followed by 12 mg and

'Adenosine has been shown to be safe and have efficacy in children and infants'

5 mg followed by 7.5 mg bolus doses, respectively. Verapamil was more successful than adenosine at the lower doses (82% vs 56%) but they appeared equally effective at higher doses (92% vs 89%) in patients without contraindications to either agent.

Thus, in 287 evaluable patients in the multicenter trials, the overall efficacy rate for adenosine in conversion of SVT to sinus rhythm is >90% which is comparable to a 7.5 mg dose of verapamil (~ 91% efficacy rate)—a

commonly used clinical dose.

Adenosine has also been shown to be safe and have efficacy in children and infants, although it does not have an FDA-approved indication in these populations. The drug produced rapid termination of most episodes of supraventricular tachycardia and facilitated the evaluation of the arrhythmia in some cases. 14,15

Adenosine may have additional value as a diagnostic agent in patients with arrhythmias other than AV re-entrant PSVT. The differential diagnosis of ventricular tachycardia (VT) from SVT may be difficult in the emergency treatment of wide complex tachycardia. If the arrhythmia is misdiagnosed as SVT and vera-

pamil is then used as a diagnostic or therapeutic agent, there is the potential for deleterious hemodynamic effects if the rhythm is ventricular tachycardia. ¹⁶⁻¹⁸ The short duration of action and lack of significant hemodynamic effects of adenosine are of particular advantage in this situation, providing a safer alternative to verapamil. ¹⁷

In patients with SVT due to atrial arrhythmias, adenosine will produce a transient, higher degree of AV block in these arrhythmias, revealing atrial activity and facilitating the correct diagnosis with little likelihood of producing significant hypotension. Once recognized, atrial tachycardias require additional, specific therapy for control (e.g., Type I antiarrhythmics, verapamil, or digitalis).

Indications and contraindications

The current FDA-approved indication for adenosine is paroxysmal supraventricular tachycardia (PSVT), including that associated with accessory bypass tracts of the Wolff-Parkinson-White syndrome. Adenosine is contraindicated in the following conditions: 1) secondor third-degree AV block, 2) sick sinus syndrome, and 3) patients with a known hypersensitivity to adenosine (unlikely).

Warnings and precautions

Arrhythmias at Time of Conversion—At the time of conversion, other arrhythmias may occur in up to 55% of patients.¹³ These typically last only a few seconds and do not usually require intervention. These may include premature ventricular contractions, atrial premature contractions, sinus bradycardia or arrest, sinus tachycardia, skipped beats and varying degrees of AV nodal block. Asystole, when it occurs, is generally brief (<4 seconds) but occasionally may be more prolonged and associated with lightheadedness or even syncope. These patients should not receive additional doses.

Drug Interactions—There are several potential drug interactions which could affect response to adenosine. ¹⁹ These are summarized in Table 1.

Asthma—As previously mentioned, inhaled adenosine has been reported to induce bronchoconstriction in asthmatic patients. Although intravenous adenosine has been used in a limited number of patients with asthma without causing exacerbation, the clinician

TABLE 1
POTENTIAL DRUG INTERACTIONS WITH ADENOSINE

Interacting Drugs	Possible Effects	Remarks
Methylxanthines • theophylline • caffeine	Causes decreased response	Monitor patient's arrhythmia response—may require increased dose
Dipyridamole	Causes increased response	Initiate therapy with reduced dose—monitor for exaggerated response
Carbamazepine	May cause increased degree of heart block	Monitor the patient's arrhythmia response
Nicotine	Chewing nicotine gum may increase hemodynamic response	Monitor the patients blood pressure and pulse

should be alert to the possibility that adenosine could produce bronchospasm in patients with asthma.

Adverse effects

Adverse effects are frequent after administration of adenosine for SVT but are usually transient and easily tolerated by the patient. Facial flushing and dyspnea which occur in 15-100% of patients are the most common adverse effects. Cardiovascular adverse effects reported after administration of adenosine include sinus bradycardia, sinus arrest, atrial fibrillation and varying degrees of AV block.

Angina-like chest pressure or pain without electrocardiographic evidence of ischemia has been described in patients with documented ischemic coronary disease and in normal volunteers who have received an IV bolus of adenosine. ^{20,21} As with noncardiac adverse effects, these effects are generally self-limiting (usually <1 minute) and generally do not require intervention.

Dosage and administration

Adenosine (Adenocard®) is available in 2 ml flip-top vials containing 6 mg/2 ml (3 mg/ml) solution in normal saline. The solution contains no preservatives. The recommended initial dose is 6 mg given as a rapid intravenous bolus (administered over 1 to 2 seconds). If the first dose does not result in termination of the SVT

(Continued on next page)

within 1 to 2 minutes, a 12 mg IV bolus dose may be administered. This 12 mg dose may be repeated in 1 to 2 minutes if the arrhythmia has not converted. It should be noted that 90+% of responses occur at the 12 mg dose—very few patients respond at doses higher than this.

Administration should be by rapid bolus intravenous injection. To be certain the solution reaches the systemic circulation, it should be administered either directly into a vein, or if administered into an IV line, it should be given as proximal as possible and followed by a rapid saline flush.

The current cost of adenosine per episode of SVT is significantly higher than verapamil by a factor of 10-12 fold per dose administered. Therefore, its use should be reserved for those patients who will not tolerate administration of conventional therapy, such as verapamil, in acute termination of SVT. Clinical characteristics which favor either adenosine or verapamil are listed in Table 2.

TABLE 2

CHOICE OF VERAPAMIL OR ADENOSINE IN TREATMENT OF SUPRAVENTRICULAR TACHYCARDIA

Patient Characteristics Favoring Verapamil	Patient Characteristics Favoring Adenosine
Previous favorable response to verapamil	Initially severe hypotension
Stable hemodynamics	Poorly compensated heart failure
Patient receiving theophylline	Recent intravenous β-blocker use
?Bronchospastic lung disease	Wide complex tachycardia of unknown mechanism ?Neonates†

[†]_Infants <1 year have been reported to have profound hemodynamic collapse after intravenous verapamil.^{22,23}

References

References noted in this article are available from the authors or the editors of IOWA MEDI-CINE.



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The Editor Comments



Marion E. Alberts, M.D.

A world at odds

A song for the Old, while its Knell is tolled,
And its parting moments fly!
But a song and a cheer for the glad New Year,
While we watch the Old Year die!
Oh! its grief and pain ne'er can come again,
And its care lies buried deep;
But what joy untold doth the New Year hold,
And what hopes within it sleep!
—George Cooper (1840-1927), The New Year

A S WE CAST ASIDE ANOTHER YEAR and look upon promises for the future, surely we can hope that "grief and pain ne'er can come again, and its care lies buried deep." The past year caused us much grief and pain

with events that leave an indelible mark.

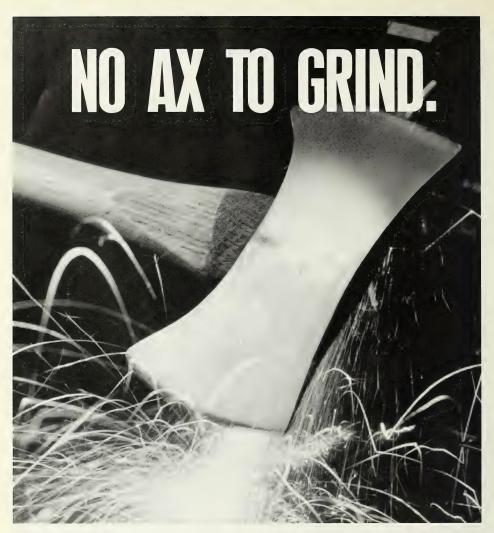
Though most of the troops have returned from active duty in the Mideast and the Kuwait oil wells have been extinguished, the unrest is far from over. Though peace talks have been initiated, they may need numerous "jump-starts" to keep them going. Unrest in the Balkan countries continues, and the atrocities leave doubt in one's mind if we have advanced from the day Cain slew Abel. In this country, we were shocked by the Senate hearings before the final swearing in of our newest Supreme Court Justice. Social problems in the work place will increase. Lawsuits will be numerous.

Candidates for public office, especially for the highest U.S. office, have begun their accusation and innuendo. Candidates will spend astronomic amounts of other peoples' money on their campaigns. Suggestions that a "cap" be placed on election expenditures fall on deaf ears. The perks of public office must be very lucrative.

We have seen the cost of health care increase. Insurance premium rates will raise about 19% next year. The cost of living adjustment for Social Security recipients will increase by a fraction over 3%. The Medicare hospital deductible is expected to increase in 1992 from \$628 to \$652. Many of the elderly will suffer financial devastation.

Much of this sounds like universal doom and gloom. Let it not be that. The United States is still the best place in the world to live. Our standard of living is of the highest order. But, we have problems. The homeless and destitute, the unemployed and those with incurable illnesses are our responsibility.

Yes, the old year had its problems. The new year holds joys untold and there is surely hope for the future. That hope must be based on faith, as well as consideration for others. Much of our society is contaminated with selfishness. We can gain much by remembering the admonition of John F. Kennedy in his Inaugural Address on January 20, 1961: "United there is little we cannot do in the host of new cooperative ventures. Divided there is little we can do—for we dare not meet the powerful challenge at odds and split asunder."—M.E.A.



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A new page

Richard M. Caplan, M.D.

A FTER 22 YEARS OF SERVICE in CME at the University of Iowa, I left that administrative post on June 30, 1991. During the months since, my column in IOWA MEDICINE has continued the banner and content, CME Notebook, although the fine print has identified me as "Coordinator of Medical Humanities." But now it's time to report to you a greater change. The editor invited my CME successor, Dr. Richard Nelson, to continue to write "CME Notebook" in months that alternate with this new page of mine, hence to be called "The Art of Medicine."

As a first step, perhaps a definition of medical humanities is in order. Many of you probably noticed that my ruminations about physicians' education often dealt, either tangentially or sometimes head-on, with topics or ideas in the domain of the humanities. Medical humanities, a term of recent coinage, encompasses the medical relationships and implications of topics traditionally found in the disciplines called "humanities": especially philosophy (and particularly ethics), history, literature and language, religious studies, anthropology, and law, for example.

When science, both knowledge and methods, began its great expansion into the world of medical practice in the late 1800s, it produced an enormous effect in ameliorating, even conquering, disease. The optimism distilled from that century and early in this one seemed well justified—for awhile. But as a century passed, medical practice in America became widely perceived as lacking something important; scientific/technical prowess

had advanced so astoundingly that it tended too often to crowd out the millenia-old doctoral function of caring for patients. The sympathetic ear, the gentle touch and the concern to provide patients with comfort, explanation and reassurance have commanded less of doctors' time and interest. The alienation, indifference and selfishness that characterize much of modern society have produced a backlash of dissatisfaction in the public, which seeks medical service that addresses what should be done in contrast to physicians' increasing fascination with what could be done. The study of that which is right to do is ethics, and thus was born medical ethics in its contemporary form.

Other subjects of the humanities, once examined, were also found to offer modes of understanding human illness (not just disease), suffering and behavior that could help relieve the increasingly narrow focus on scientific knowledge alone—not because such knowledge and techniques were themselves incorrect or undesirable, except as they crowded out other components of what it is to be human. Thus medical education over the nation has been paying more attention to this cluster of subjects whose insights, I believe, can produce more competent and compassionate care for the sick and the worried well.

I'm glad to focus my energy increasingly on this area of learning that addresses what used to be called the art of medicine—not art as something opposing science but as completing and making whole an ancient profession devoted to healing the wounds and illnesses of individuals and of society. I hope my shift in emphasis and writing may attract your sympathetic consideration and reading time.

Dr. Caplan is Coordinator, Program in Medical Humanities at the University of Iowa College of Medicine.

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Biomedical Ethics

Patient self-determination act

Robert Weir, Ph.D.

A SMALL PART OF A MASSIVE piece of legislation passed by Congress in 1990 was a bill called the Patient Self-Determination Act (PSDA). This new law became effective December 1, 1991, and is having an impact on all health care facilities that receive funds from Medicare or Medicaid programs.

The PSDA is significant because of the ethical position it advances. More than any other federal legislation, the PSDA affirms the importance of respecting decisions made by autonomous persons about their health care, whether those decisions were (1) voiced or written at any time before the person became a patient in a health care facility, (2) written by that person as part of the admission process, or (3) communicated (or changed) by that person after admission to a health care facility.

The PSDA mandates that hospitals and other health care facilities provide materials and programs to help educate staff members and the public about advance directives ("living wills"). These educational materials and programs are also intended to make health care professionals and other citizens better informed about their right to accept or refuse medical treatment. This required education gives adults an opportunity to appoint a trusted relative or friend as a surrogate if they lose the capacity to make health care decisions.

Specifically, the PSDA will require hospitals and other health care facilities to:

 provide written information to all adult patients concerning their rights under state laws to accept or refuse medical or surgical treatment, and to formulate advance directives;

 provide written information to all adult patients regarding the institution's policies for implementation of these rights;

• give this written information to patients during the admission process as a hospital inpatient, a hospice patient, or a resident of a skilled nursing facility;

 document in each patient's medical record whether or not the individual has executed an advanced directive;

 avoid discrimination based on whether individual patients have signed advanced directives:

ensure compliance with patients' advance directives, consistent with state law;
 and

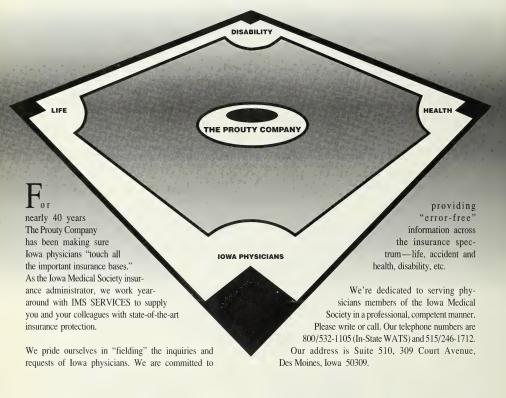
 provide staff and community education on advance directives.

The importance of the PSDA is clear. The U.S. Department of Health and Human Services has developed materials explaining patients' rights for distribution by health care facilities. The National Council on Death and Dying has a National PSDA Coordinating Committee, with participants from the AMA, the AHA and many other medical and health care organizations. Ethics committees in many hospitals and nursing homes have developed institutional policies and procedures for implementing the new law.

Editors' note: The Iowa Medical Society, Iowa Hospital Association and Iowa State Bar Association have developed a patient education pamphlet entitled "Advance Directives for Health Care: Deciding Today about Your Health Care in the Future."

Dr. Weir is director of the program in biomedical ethics for the University of Iowa College of Medicine.

COVER YOUR INSURANCE BASES



Sexual harassment in the workplace: minimize your liability

HARGES RAISED DURING HIS confirmation hearing that Supreme Court Justice Clarence Thomas sexually harassed a former aid has ignited what the Wall Street Journal called a "firestorm of debate and discussion."

Federal and state civil rights laws prohibit an employer from discriminating on the basis of sex. For years, courts have recognized that this prohibition is violated when a "superior" employer ties some employment benefit to a subordinate agreeing to sexual conduct or favors. This is what is known as "quid pro quo" sexual harassment. Courts have generally held that an employer is strictly liable for "quid pro quo" sexual harassment by supervisory employees, regardless of whether or not the conduct is prohibited by policy.

In 1986, the U.S. Supreme Court held that a plaintiff need not prove loss of a tangible benefit to prove a violation of the federal law prohibiting discrimination in employment on the basis of sex. It held that a plaintiff may establish a violation by proving that discrimination (i.e., differential treatment) based on sex has created a hostile or abusive work environment. The Iowa Supreme Court reached a similar conclusion in 1990.

Employers liable for

hostile environment

An employer may face liability for "hostile work environment" sex discrimination even where alleged perpetrators are not supervisory employees. In cases involving Title VII and the Iowa Civil Rights Act, Iowa employers have been found liable for "hostile work environment/sexual discrimination" created by the conduct of non-supervisory co-employees. Under the law, an employer may be liable for the conduct of non-employees who "harass" employees as well. As a general rule, courts have declined to hold an employer strictly liable for unlawful conduct in this area.

In all the reported court decisions where liability has been imposed, the victims complained in some way to responsible managment officials about the objectionable conduct.

'Train and sensitize your supervisors, as well as your entire workforce. As the courts have pointed out, conduct males view as unoffensive may be offensive to females."

The employer's liability was founded upon its failure to respond to halt the practices. In one case, judgment was entered against the Iowa corporate employer and against the individual supervisor to whom reports/complaints were made. In every reported court case involving an Iowa employer where a violation has been found, the victim was awarded damages for emotional distress. With the enactment of the Civil Rights Act in 1991, victims who are covered by Title VII of the Civil Rights Act of 1964, as amended, may seek jury trials and compensatory and punitive damages.

Minimize your risk

There are several things that an employer should do to minimize the threat of liability for a hostile work environment/sexual harassment claim.

(Continued on next page)

This article was written by Russell Samson, J.D., a shareholder in the Des Moines law firm of Dickinson, Throckmorton, Parker, Mannheimer & Raife, P.C

At a minimum, there should be a written, disseminated policy emphasizing that sexual harassment will not be tolerated in the workplace. Some courts have extended the prohibition on discrimination to any conduct that is offensive and unwelcome even if not strictly sexual in nature. The phrase "sexual harassment" may not provide enough information as to the conduct that is prohibited. The policy may need to identify such things as use of suggestive comments, sexual language, obscene jokes, patting, pinching or unnecessary touching, and literally all verbal comments, gestures, physical contacts, posting of pictures or other conduct. It is impossible to put together an allinclusive list, but the scope is broader than "quid pro quo."

The policy should also outline a complaint procedure for employees who believe the policy has been violated. The procedure should be one that will encourage employees to come forward. Employers should consider the many ways in which complaints may arise and make certain there is at least one avenue for an individual to utilize. The policy should state that an employee who brings a complaint will suffer no retaliation as a result. Finally, the policy should notify employees that any violation, including the "no retaliation" clause, will result in discipline up to and including discharge.

One goal of the policy should be to facilitate the communication of all workplace concerns, whether they constitute a statutory violation or not.

Enforcing the policy

Employers should ensure that their supervisors, managers and entire workforce are fully aware of federal and state laws and the company policy, in the area of sexual harassment. Education of supervisors is critical—"Notice" to an employer sufficient to trigger liability may not come in the form of a formal complaint but from the employer (i.e., the supervisor) merely being aware of the conduct in question.

Assuming an employer receives some notice of sexual harassment, its liability may be determined by its response. Both the Iowa Supreme Court and federal courts have indicated that an employer with knowledge of a problem will not be liable if the response is immediate and appropriate.

Employers must treat all complaints seriously. A person receiving a complaint should

gather the facts but not make judgments. Many employers have gotten into trouble because of comments made at this stage. The complainant should be told that she/he will suffer no retaliation and urged to let the employer know if she/he feels this promise has not been kept. Employers need to be especially cautious of situations where concerns are expressed but the victim asks the employer not to do anything. No complaint should be ignored.

All complaints should be handled with dispatch. After getting the facts from the com-

'Courts have generally held that an employer is strictly liable for ''quid pro quo'' sexual harassment by supervisory employees, regardless of whether or not the conduct is prohibited by policy.'

plainant, interview the accused. Where there is dispute, the investigation should not be limited to "she said/he said." The investigation should be thorough and designed to gather facts—not disseminate allegations.

After the investigation

As a general rule, the law does not require employers to fire all harassers. The level of discipline should, however, "fit the crime." The purpose is to punish the perpetrator and assure that the conduct does not continue. In some circumstances, removal of the perpetrator from a work area may be necessary.

In some cases it may not be possible to determine what really happened. Even here, it is important the matter be resolved. At the very least, an employer can re-emphasize the company policies to all parties. The complaining party may be asked for additional evidence, told that any subsequent incident should be reported immediately and reminded of the "no retaliation" policy. Documentation of the complaint, the investigation and the results should be made.

Conclusion

"Hostile work environment/sexual discrimination" is a potential quagmire of liability. Fre-

quently, there are no witnesses. Nevertheless, it is a situation no employer can ignore.

To minimize liability:

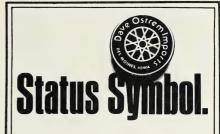
• Adopt and implement a policy in this area—actively solicit all complaints and gripes. It is far preferable to find out about problems at an early stage than in a courtroom. Merely because a situation may not meet the legal standards does not mean it should be ignored. All complaints should be treated seriously.

Train and sensitize your supervisors, as well as your entire workforce. "Boys will be boys" is not a defense. As the courts have pointed out, conduct males view as unoffensive may be offensive to females. Once channels of communication are opened, problems

may be resolved.

• Be serious about your policies—enforce them. While you need not terminate every person against whom a complaint is filed, follow up every complaint (whether formal or not).

Editors' note: For more information on office policy on sexual harassment, contact Dave Furneaux at the Iowa Medical Society.



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About Iowa Physicians

Items in this column are compiled from newspaper clippings from the Iowa Press Clipping Bureau. News from individual physicians, clinics and hospitals is welcomed and encouraged.

Dr. Rodney Miller, Sac City, was recently named 1991 Iowa Family Physician of the Year at the Iowa Academy of Family Physicians' 43rd Annual Meeting in Des Moines. Dr. Miller has practiced in Sac County for 30 years. He will be Iowa's nominee to the American Academy of Family Physicians for the 1992 National Family Doctor of the Year. Dr. Todd Mahr, a pediatric allergist-immunologist at Gundersen Clinic in West Union, was recently appointed to the faculty of the National Asthma Education Program at the National Faculty Conference in New York City. Dr. Carol Aschenbrener, Iowa City, has been appointed to represent the AMA on the National CME Accreditation Council, Dr. Aschenbrener is chairman of the IMS Board of Trustees. Dr. Kathy Perisho Cook has joined the practice of Dr. Barbara Lindman of Iowa City. Dr. Cook received the M.D. degree from the U. of I. College of Medicine and completed a dermatology residency at U. of I. Hospitals and Clinics. Dr. Jane Winston and Dr. Robert Lee have joined Dr. Tom Evans and Dr. Matt Petersen at Iowa Physicians Clinic Family Practice, Des Moines, Dr. Winston received the M.D. degree from the University of North Dakota School of Medicine, Grand Forks, North Dakota and served a residency at the University of North Dakota Family Practice Center, Fargo, North Dakota. Dr. Lee received the M.D. degree from the U.of I. College of Medicine and completed a residency in the Family Practice Residency Pro-

gram, Grand Rapids, Michigan. Dr. Shelley Breven has joined Dr. Janet Gilbert at the Williamsburg Family Practice Clinic. Dr. Breyen received the M.D. degree at University of Minnesota Medical School, Minneapolis, Minnesota and completed a family practice residency at U. of I. Hospitals and Clinics. Dr. Terrence Briggs, Marshalltown, has been elected chairman of the Iowa Section of the American College of Obstetricians and Gynecologists. Dr. Briggs is affiliated with Marshalltown Medical and Surgical Center. Dr. Richard Roski, Davenport, was recently named vice-president of the Congress of Neurological Surgeons at that organization's annual meeting in Orlando, Florida. Dr. Roski is in private practice in Davenport. Dr. Raul Ruiz, Eldora, has resigned as Hardin County deputy medical examiner, a position he held for 13 years. Dr. David Hussey, professor, Division of Radiation Oncology at U. of I. Hospitals and Clinics, was named treasurer of the American Society for Therapeutic Radiology and Oncology at the Society's recent meeting in Washington, D.C. Dr. Robert Forbes, associate professor of anesthesiology at the U. of I. College of Medicine, has been awarded the 1991 Lewis D. Holloway Award for Research in Health Sciences Education. Dr. Forbes received the award for developing and evaluating a clinical simulation program for teaching fiber-optic endotracheal intubation. The results of his research were published in the Canadian Journal of Anaesthesia.

Deaths

Dr. Ernest Theilen, 68, Iowa City, died October 19 at U. of I. Hospitals. Dr. Theilen received the M.D. degree from the University of Nebraska College of Medicine, Omaha, Nebraska and completed an internship and residency at U. of I. Hospitals and Clinics. He was a professor in the internal medicine department at the U. of I. College of Medicine and director of the coronary care unit and electrocardiography laboratory at U. of I. Hospitals and Clinics.

Dr. Worthey Boden, '79, Sioux City, died October 9. Dr. Boden received the M.D. degree from the U. of I. College of Medicine and completed his residency there also. He practiced in Knoxville prior to locating in Sioux City where he practiced until his retirement in 1980. He was a member of the International College of Surgeons and an life member of the Iowa Medical Society.





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GENERAL SURGERY — Delaware County Memorial Hospital is actively recruiting a general surgeon to replace Dr. James Stull who has had a full time surgical practice for the past several years. Dr Stull is anticipating retirement in the next few years (timing is flexible). Presently there is a hospital-based full surgical practice which includes general surgery, obstetrics, gynecology and endoscopy. Please contact James Stull, M.D. at 319/927-3232, Larry Severidt, M.D. at 319/927-2629 or Craig Thompson, D.O. at 319/933-6277.

PEDIATRICS - Marshfield Clinic, a 400-physician multispecialty group practice, is seeking BE/BC pediatricians to join expanding regional centers in Chippewa Falls and Rice Lake, Wisconsin. These are beautiful, wooded Wisconsin areas with an abundance of lakes, rivers and streams. Both communities offer a thriving economic environment, clean air, low crime, excellent schools and exceptional 4 season recreation. Chippewa Falls is a community of 22,000 with 8-10,000 permanent residents living around adjacent Lake Wissota. It borders Eau Claire, Wisconsin, a city of nearly 80,000 which includes a major campus of the University of Wisconsin. Rice Lake is a lakeside community of 8,500 people. In addition to excellent primary and secondary schools, both public and parochial, educational opportunities include a U.W. Center and V.T.A.E. campus. Both opportunities have beautiful new clinic buildings situated adjacent to comparably modern and progressive hospitals. In addition to their many local resources, the nearby proximity of major metropolitan areas (i.e., 11/2 hours from Minneapolis/St. Paul) provides a catalog of readily accessible cultural activities, shopping, fine dining and professional spectator sports. Each opportunity has its own special qualities with more attractive features relative to individual needs and preferences. Emphasis on life-style and quality practice is combined with a guaranteed salary and outstanding fringe benefit package. If this combination of professional excellence and life-style made possible through the backup resources of a leading medical center in conjunction with the uncommon, varied beauty of Wisconsin's land and lakes sounds interesting to you, please send CV and references to David L. Draves, Director Regional Development, 1000 North Oak Avenue, Marshfield, Wisconsin 54449 or call 1/800-826-2345, extension 5376.

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(Continued on next page)

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DISEASES AND SURGERY OF THE COLON AND RECTUM

Unpolarizing our professions

"Unfortunately, it's only taken a couple of issues to polarize our professions."—Warren Wulfekuhler, M.D., Mason City

"I have learned a great deal about physicians over the past several years."—Diane Kutzko, J.D., Cedar Rapids

WHO HAS THE MOST TO GAIN when certain professions do a better job of cooperating? The public, say Iowa physicians and attorneys who have been collaborating on a number of important educational projects.

Dr. Wulfekuhler is chairman of the IMS Medical-Legal Committee, which meets periodically with representatives of the Iowa State Bar Association (ISBA) Health Law Section. These meetings are the point of origin for recent projects involving the 2 professions.

"Attorneys write our wills, do our taxes and estate planning, handle our divorces and do many other things for physicians. Likewise, physicians provide medical care for attorneys," comments Dr. Wulfekuhler. "Unfortunately, a few issues placed us in adversarial positions which can sometimes be detrimental to the patient-client/physician/attorney triangle."

Norene Jacobs, a Des Moines attorney who is a member of the ISBA Health Law Section, concurs: "When the patient and the client are the same person, the person is better served by professionals who have a cooperative working relationship."

"The public can only gain from physicianlawyer cooperation," adds Ms. Kutzko, the ISBA's liaison to the IMS Medical-Legal Committee. "Pooling their respective expertise, physicians and lawyers have addressed issues of great importance to the public."

During the past several years, the IMS and ISBA have cooperated on projects including a

series of statewide seminars exploring issues of mutual interest; a patient education brochure explaining Iowa's Living Will and Durable Power of Attorney for Health Care laws and an updated version of the principles of practice governing physician-attorney relationships.

"I firmly believe Iowa has reasonable legislation concerning living wills and medical powers of attorney because of the collaboration between the IMS and the Bar," comments Ms. Kutzko. "I've noticed this collaboration has a ripple effect—other groups are looking to the Bar and the Medical Society as partners on health care issues."

Dr. Wulfekuhler concurs: "We need to increase dialogue between the professions concentrating on issues we agree upon. This will build trust and the spinoff will help defuse some of the problem issues. The public will benefit."

"Attorneys are generally articulate, concerned, innovative, well informed and willing to compromise," he continues. "They are interested in having a good relationship with the medical profession."

Ms. Jacobs has this comment: "I have come to appreciate that many of the health care issues resolved in the legal system are really social, public policy or ethical issues that might be better addressed outside the courtroom."

"I have become very aware of how highly regulated a physician's practice is and how much time is diverted from patient care issues," concludes Diane Kutzko. "I've also learned that right-to-die issues are best handled between the physician and the patient's family—the court should be the last resort."

Dr. Wulfekuhler, Diane Kutzko and Norene Jacobs say they have gained a greater understanding of the other profession through their work in the medical-legal arena.

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BRIEF SUMMARY

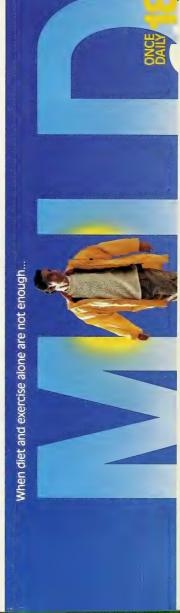
Contraindications: Severe LV dysfunction (see Warnings), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick simus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg. WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapami should be avoided in patients with severe LV dysfunction (e.g. ejection faction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum dispitation and/or distretise febrer Calan SR is used. Verapami may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapami. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and ancessory Aby pathway (e.g. WPW or LG. syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid conduction across the accessory pathway bypassing the AV node, producing a very rapid and control of the control of the produced by a contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree abolick requires reduction in dosage or, rarely, discontinuation and institution of appropriate degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate discontinuation and institution of appropriate and of the production and an accession of the received in the progression to 2nd- or 3rd-degree abolick requires reduction in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use

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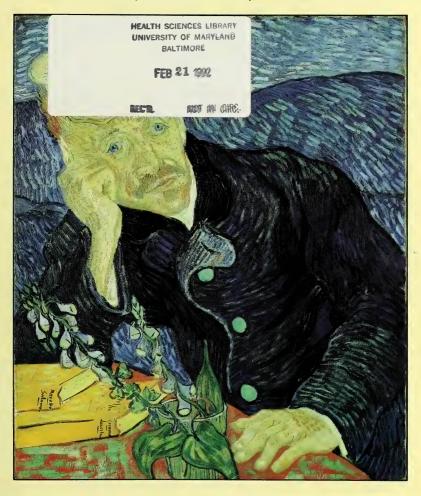


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February 1992

Journal of the Iowa Medical Society

Physicians and Depression



AMA study reveals profile of suicidal physicians lowa physicians tell how they combat stress

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"Portrait of Dr. Gachet," featured on this month's cover, is one of two paintings Vincent van Gogh did of his friend Dr. Paul Gachet. Vincent was under the care of Dr. Gachet — a man who was also subject to intense melancholy — during the last months of his life. Read about their strange relationship and Vincent's tragic end in "More about the Cover" on page 65.



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R. Bruce Trimble, M.D.

Colleague

EXCEPT PERHAPS in the context of terminal lilness, suicide is always tragic and difficult fully to comprehend. The impact is particularly forceful when another physician dies. Our hearts go out to the families of these physicians. The sense of hitting close to home should perhaps also lead us to reflect on the nature of our relationship to other physicians.

Most of us automatically refer to other physicians as "colleagues." Not just members of our group and specialties, but also those even for whom we feel no particular closeness and those we don't know at all.

Why do we say colleague instead of "co-worker" or "associate"? According to the dictionary, colleague is synonymous with partner and suggests a warmth and respect not implied by the other terms.

The way we refer to each other reflects the closeness physicians have traditionally felt. Outsiders note this in the peculiar sense of humor we share, our alleged reluctance to testify against each other, our strong support for professional associations and the tendency of physicians to come to medical meetings and hospital breakfasts for years after retirement.

Our sense of community comes from pride in our profession, our common experience in a long and intense educational process and our mutual understanding of the responsibilities of medical practice.

This collegiality may be threatened by increasing specialization and by economic pressures which encourage us to see ourselves as marketplace competitors or to emphasize loyalty to our hospital as more important than professional ties. If so, this would be a major loss. Collegiality is more than clubbiness.

Patient care today frequently requires the coordinated expertise of multiple specialties. This is best accomplished if we have a sense of mutual emphathy and respect regardless of speciality or practice arrangement. A strong sense of community is important in discharging professional responsibilities for quality assurance and speaking with a common voice on issues such as reform of health care delivery.

Every day we make decisions of great significance to our patients' welfare even when we are tired, hurried and beset by uncertainty. We share our emotional resources with our patients. We set high standards for ourselves and others and frequently question whether we could have changed an unsatisfactory outcome. Medicine, in short, is emotionally draining. We need the support of our families, close friends and perhaps a religion or philosophy. We also need the understanding and support of those who walk in similar shoes. A strong sense of collegiality makes it easier to accept and to give that support and to sense when it is needed.

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The Editor Comments



Marion E. Alberts, M.D.

There's a lot to be said for brevity

It has often been said there's so much to be read, you never can cram all those words in your head.

So the writer who breeds more words than he needs is making a chore for the reader who reads.

So that's why my belief is the briefer the brief is, the greater the sigh of the reader's relief is.

—Theodor Geisel ("Dr. Seuss")

SI APPROACH THE MARK OF 21 years as A scientific editor of IOWA MEDICINE I have learned the concept of being brief. Our scientific presentations are more concise and less pretentious. We have emphasized that good medical presentations do not require numerous words that add little or nothing to the text. Authors of manuscripts have demonstrated increasing skills in good writing. True, there are some that require considerable editing without the loss of content value. Our staff has been very adept at this work with minimal problems. In fact, many authors have expressed an appreciation of the manner in which their manuscripts have been edited.

Two members of our staff recently attended a writer's workshop. They received some valuable lessons in writing and publishing. Prose writers can learn from poetry a style that has some basic ingredients to make for better presentation. Such considerations as intensification, fresh perspective, compression, clarity, integrity, rhythm, creativity, excitement and a courage to experiment provide for better writing.

An editor has several important goals that polish the author's message. These are to assure the writings be considerate, correct, concise and clear. All these we attempt to do. We will continue to assist our authors and in so doing continue to produce a quality publication; a publication easy to read and serving our readers with concise reports of integrity and worth.

The staff of *IOWA MEDICINE* stands ready to give assistance to authors who submit manuscripts for our consideration. We realize physicians have varying skills in writing. Our task and responsibility remains to lend assistance short of rewriting the entire manuscript. We welcome papers for consideration, but cannot assure that all will be accepted for publication. A coordinated effort by writers and our staff can continue to provide what we consider an excellent journal that will benefit our readers. —*M.E.A.*

When physicians commit suicide

Data collected from extensive studies often contradict popular conceptions about physician suicide.

Donald Black, M.D.

Iowa City, Iowa

THE HIGHLY PUBLICIZED DEATHS of several I lowa physicians over the past year have brought the sensitive subject of physician suicide to the public's attention. Media coverage of these unfortunate events focused on the strain of a medical career and how stress may have influenced the deaths.

Whether stress of any other single variable can adequately explain a suicide is doubtful, but the discussion brings into focus a larger question. Why do physicians kill themselves? Is there something unique about a physician's life that would drive one to commit suicide? Is there anything unique about the person who chooses to enter medicine and do these pre-existing characteristics predispose to suicide?

Epidemiology of physician suicide

It is generally thought physicians have high rates of suicide. As a group, this generalization is true, but early work in this area failed to take into account the effect of age and gender on suicide rates. In fact, nearly 3% of male physicians and 6.5% of female physicians commit suicide.1 While the rate for male physicians is nearly three times the rate for suicide in the general population, it is equivalent to that for males over age 25 years. Therefore, male physicians are at no greater risk for suicide than are similarly aged males in the community.

The rate among women physicians, however, is much higher than expectation. It is about four times the rate for similarly aged women in the general population. Data from Europe support the conclusion that the difference between rates of suicide in men and women is genuine. The high suicide rate is not unique to women physicians, since other women professionals (e.g., chemists, psychologists) also have high rates.

There has been much speculation about whether suicide rates differ by medical specialty. There is some evidence to suggest psychiatrists have a two-fold higher rate of suicide in the United States. High suicide rates have also been reported in some surgical subspecialties (e.g., ophthalmology, otolaryngology) and anesthesiology. This is attributed to the ready access these professionals have to potentially lethal drugs. The limitations of these studies make it impossible for us to know if the differences are genuine.

Unfortunately, when a physician commits suicide, it occurs during his or her most productive years. The average age of the

Dr. Black is with the University of Iowa College of Medicine Department of Psychiatry.

male physician who commits suicide is around 50 years; it is somewhat younger for female physicians. Married physicians tend to have the lowest rates of suicide, a fact also true for suicide completers in the general population.

Psychiatric disorders among physician suicides

Psychiatric disorders occur in more than 90% of suicide completers.2-4 Based on this evidence, Murphy has concluded psychiatric illness is a necessary condition for suicide.5 This conclusion would be true for physician suicides as well. Depression and alcoholism are the most common psychiatric diagnoses among suicide completers, but other diagnoses are found as well, including drug addiction, anxiety disorders, schizophrenia and personality disorders. While careful studies have not been done to show the distribution of psychiatric disorders among physicians who commit suicide, it is almost a certainty one would be present. The "rational" suicide—a carefully considered appraisal of the need for death in the absence of a mental illness—is quite rare.

The fact that physicians commit suicide suggests many probably suffer from common psychiatric disorders. One study that included nearly all women physicians in St. Louis. Clayton et al., reported that between 39% and 51% (depending on the definition of the syndrome) had a history of primary affective disorder, a frequency considerably higher than the rate of depression for women in the general population.

Other than this study, there is little known about the prevalence of psychiatric disorders among physicians. However, it is unlikely schizophrenia or related disorders would be found, since they generally strike early in life and would most likely prevent one from completing medical training.

Psychiatric disorders among physician psychiatric patients

Another way to look at the relationship between psychiatric illness is to examine rates of psychiatric disorders among identified physician psychiatric patients. Controlled studies show depression and substance abuse occur more frequently among physicians than control subjects; substance abuse is the most likely diagnosis.¹ These studies support the hypothesis that substance abuse and mood disorders are major contributors to suicide in physicians.

Unfortunately, studies based on a sample of persons seeking treatment are inherently biased. While substance abuse is frequently found in physician psychiatric patients, it is

'While the rate for male physicians is nearly three times the rate for suicide in the general population, it is equivalent to that for males over age 25 years.'

not known whether the rate for substance abuse is actually higher among physicians than in the general population. The increasing problem of polysubstance use complicates the problem. A survey of medical students and physicians found psychoactive substance use was widespread and illicit drugs were regularly used by 16% of medical students and nearly 10% of physicians.⁷

In a study of 100 alcoholic women physicians, only 40% were addicted to alcohol alone.⁸ In some instances, suicide attempts among these women were attributed to depression, not substance abuse, suggesting considerable substance abuse in physicians may be undetected. These data add further weight to the conclusion that substance abuse and depression contribute to physician suicide.

Role strain and physician suicide

It has often been reported that physicians experience unique stressors associated with medical training and practice due to excessive time and work demands, the physician's responsibility for human life and inadequate social supports. These stressors may be problems for some physicians, but since the suicide rate is no higher among male physicians than that for the general population, it is difficult to believe the stress of being a physician plays a unique role. Lawyers, accoun-

(Continued next page)

tants and factory workers each have unique stressors as well.

The role strain of a medical career may have more relevance to women physicians, since their suicide rates are higher than expected. The high prevalence of depression among women physicians could also explain their high rate of suicide, since depression often leads to suicide.10 Some of the stressors blamed for the suicides include the discrimination many women experience, the lack of adequate female role models, lack of family and institutional supports and the demands on women due to their dual responsibilities at home and in the office. Whether any of these stressors actually lead to suicide is impossible to know.

The issue of role strain is problematic, since stress levels are thought to vary by specialty. Surgeons, for example, are commonly

'The role strain of a medical career may have more relevance to women physicians, since their suicide rates are higher than expected.'

believed to experience the most stress. However, popular ideas do not seem to correlate with suicide data among medical specialties; if job stress is related to physician suicide, surgeons would have the highest rates, not psychiatrists. This example points to one of the problems in evaluating the effect of stress: How does one quantify stress? What may be stressful to one person may not be for another. Although stressful situations seem to be a necessary ingredient in prompting a vulnerable individual to commit suicide, it is not clear whether the role strain experienced by the physician is unique.

Management of suicidal behavior

While physicians may tend to underdiagnose psychiatric illness in other physicians for personal and professional reasons, the first step in managing the potentially suicidal physician remains the recognition and diagnosis of the psychiatric illness. Physicians, family and friends must not assume a physician should

know how to care for him or herself when a psychiatric illness develops any more than they would expect the physician to care for him or herself if a serious physical illness occurred. It has been said doctors cooperate poorly with psychiatric treatment since they are used to being in charge and may try to manipulate their own care. Whether true or not, physicians must not be treated any differently from other suicidal persons, even if this means involuntary hospitalization.

Predicting which individuals will commit suicide is fraught with difficulty. Although many risk factors are frequently associated with suicide (e.g., psychiatric illness, advancing age, male gender, etc.), the false positive rate for them is very high. 11 Most people with these risk factors will never commit suicide. For example, virtually all suicide completers have an identifiable psychiatric disorder, yet most psychiatric patients will never kill themselves. The only rational approach to prevention is to have an awareness of suicide risk factors and to provide comprehensive psychiatric care and close follow-up.

When caring for the suicidal physician, the caregiver must inquire about suicidal thoughts and potential behavior. 12 It is not enough to simply inquire about depressed mood. The physician must inquire about the presence of suicidal thoughts, a history of suicidal attempts, any contemplated suicide attempts and so on. Since the suicidal urge waxes and wanes during an episode of depression, these questions must be asked about repeatedly.

If it is determined the potential for suicidal behavior is serious, the patient should be hospitalized. It is not fair to entrust the care of a suicidal person to family and friends. In the hospital, 24-hour care and observation can be provided, while treatment is

carefully monitored.

Counseling suicide survivors

When a physician commits suicide, it undoubtedly has an impact on the caregiver, as well as the patient's family. The treating physician will have a number of responsibilities in the aftermath of the suicide. If it occurs in the hospital, this will include notifying family, hospital staff and officials and other patients who may have been close to the deceased. The clinician should meet with the

family and staff to provide counseling, encourage ventilation of feelings and provide support. Survivors should be educated about the grieving process; it should not be assumed they will have an easier or more difficult time coping with the tragedy because of their association with the medical profession. Kaye and Soreff have provided a useful summary of the psychiatrist's responsibilities after a patient commits suicide.13

Conclusions

Although the subject of physician suicide generates intense media interest, physicians who commit suicide are similar to the general population with regard to suicide. Overall, the rate of suicide among male physicians is probably not different from a sample of similarly aged men from the community; women physicians are at higher risk, however. Whether psychiatrists, certain surgical subspecialties, or anesthesiologists are at higher risk needs additional study.

It is likely a physician who commits suicide has a diagnosis of depression or substance abuse, or possibly both. The issue of role strain needs further study, since it is often alleged that physicians suffer unique stressors that may lead to suicide.

The best way to handle physician suicide is to prevent it through careful identification and management of potentially suicidal physicians. Although this task may be more difficult with physicians than other patients, caregivers must be as aggressive as necessary to ensure the physician psychiatric patient re-

ceives appropriate treatment.

The untimely death of a physician is a tragedy personally and for society. The community has an investment in the physician's education and his or her potential professional contributions to the community. Although it is difficult to argue a physician's life is more valuable than another, it is something we, as physicians, must be alert to, and seek to prevent.

References

References noted in this article are available from the author or the editors of IOWA MEDI-



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Coping with stress physicians share their secrets

Rowing and gardening are just two of the many activities these lowa physicians count on to help them relax and relieve the stress of practicing modern medicine.

EXPERTS NOW BELIEVE STRESS is a major factor in both mental and physical illness. IOWA MEDICINE asked several Iowa physicians how they cope with stress and they offered some interesting theories about how it affects the lives of physicians.

Dr. John Gay, a pediatric cardiologist in Des Moines, says he and Dr. Marion Alberts, *IOWA MEDICINE* scientific editor, share the same secret to relaxation: "Dr. Alberts and I are soulmates with dirty fingernails—our se-

"...we're soulmates with dirty fingernails ..."



cret to relieving stress is gardening. Maybe there's something in the personality structure of pediatricians that makes us want to get our hands dirty! I used to jog before I developed back problems, but that wasn't as fulfilling. There are times when I've been out gardening at 10 p.m. In the wintertime, I go through catalogues planning what I'll plant in the spring."

Dr. Warren Bower, a Grinnell surgeon, says stress felt by some physicians may not necessarily be occupational: "Certain people are more subject to stress and depression—no matter what their profession. I have felt some added stress because of third party reg-

"...I get away by myself..."



ulations, etc., but my way of handling it is to have a good office staff who can deal with it. I think there are other specialists such as family practice physicians who feel more stress than surgeons. I think it's important to relax, and I get away by myself whenever I can. Though I don't mean to be rude, I don't socialize with other physicians because you end up talking about medicine all the time."

Dr. Paul Gordon, a Mason City family physician, says strenuous exercise is his choice: "When I feel stress, the thing that helps the most is exercise—outside. I ride a bicycle during the summer, sometimes even

"... skiing heightens my senses ..."



in the winter. I also love daytime or nighttime cross country skiing—it heightens my senses. I can also relax by just laying on a dock with the waves lapping around me. Getting rid of stress is very important—I believe it plays a bigger role in a physician's life than anyone realizes."

Dr. Patricia Connell, a Waterloo family practice physician, says exercise is an underrated stress reliever: "I participate in aerobics and definitely believe this exercise helps me relax. I have season tickets to the theater and the symphony. I'm a Hospice volunteer and I do volunteer work in my church and the school. Yearly, I take a one-week retreat to an

"... exercise helps me relax ..."



island in Wisconsin—it's a wonderful getaway. I'm fortunate also because within my practice we have a behavioral science coordinator who helps us with interventional group therapy activities. I think there's more awareness of the role of stress in our lives which is part of the new emphasis on wellness, but I don't believe physicians in general are good at coping with stress." **Dr. Dan Waters**, a Mason City heart surgeon, says the sport of rowing provides a sorely-needed getaway: "Rowing is physically strenuous and is a big stress reliever. It's intense and it requires concentration and timing. I think it's important to have even just one thing that changes your focus—a mental vacation. It could even be something

"... family doctors have it worse ..."



mindless like mowing the lawn. I don't think it's the work of practicing medicine that's the problem—I think most physicians realize they're choosing a stressful career. Where the stress comes in is the amount of your time the practice takes. I think family doctors probably have it worse than surgeons. I also think physicians who practice in a climate of medical politics are under more stress."

Dr. Sherry Bulten, a Humboldt family physician, says stress plays an extremely important role in a physician's life, particularly in rural Iowa. "Most of us are practicing in a shortage area, whether or not the government has designated it. There's no full time emergency room coverage and you're always

"...learn to say no without guilt ..."



(Continued next page)

running back to the hospital. Also, the family organizational duties are my responsibility, though my husband is excellent about helping. I've learned to relax in our family hot tub. There's no television or no telephone and the whole family is in a small area so we have to talk.

"Physicians don't do a good job of coping with stress. We're taught to be in control and not to deal with our own limitations. I'm still working on saying "no" without guilt—it's an important coping skill. I might add that the IMS Women in Medicine Committee is investigating an annual conference, and one of the program topics will be coping, relieving stress and networking."

Dr. Patricia Harrison, a Cherokee family physician, believes her conscious effort to focus only on taking care of patients—not bureaucratic hassles—helps keep her stress level at a minimum: "It's very important to learn how to manage your practice and have a

staff you trust so you can delegate and not have to wonder if it got done correctly. I relax on a stationary bicycle and I lift weights. Also, you must have close friends you can talk things over with. Other than that, I have a tendency to ignore any stress and keep doing what needs to be done."

In the March issue of IOWA MEDICINE, two family physicians discuss the highs and lows of living and practicing in rural lowa.

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The artist and the doctor

IN MAY OF 1890, suffering from poor health after a number of bizarre psychotic episodes during the previous 18 months, Vincent van Gogh went to recuperate in Auvers, a small picturesque village about an hour northwest of Paris. Dr. Paul Ferdinand Gachet, a 62-year-old French homeopathic physician who lived in a large villa in Auvers, was to provide medical care to Vincent.

In a letter to his brother Theo, Vincent described Dr. Gachet, the subject of the painting on the cover of this month's *IOWA MEDICINE*:

"Dr. Gachet gives me the impression of being rather eccentric, but his experience as a doctor must keep him balanced enough to combat the nervous trouble from which he certainly seems to be suffering at least as seriously as I."

Dr. Gachet, who wrote his doctoral thesis on melancholy, was interested in methods considered extremely modern by the medical community. It is said he was one of the first to use electricity in the treatment of illness.

Gachet was an avid collector of art, particularly the works of the impressionist painters; in various letters, van Gogh mentioned paintings by Cezanne and Pissarro owned by Dr. Gachet. Dr. Gachet had a practice in Paris a few days a week, but spent much of his time in Auvers where he painted, made etchings and printed on his own press.

Vincent settled into an inn in Auvers but began going to Dr. Gachet's house to paint. He painted several pictures of Gachet's garden which he simply gave to his host. Dr. Gachet asked Vincent to paint his portrait and, noting Gachet's "grief-hardened face," Vincent completed two portraits of Gachet. He told fellow artist Paul Gauguin, "I have painted a portrait of Dr. Gachet with the heart-broken expression of our time."

To his brother, Vincent wrote:

"Dr. Gachet is more sick than I am. He seems very reasonable, but he is as discouraged about his job as a doctor as I am about my painting."

To Theo, Vincent described the portraits of Dr. Gachet, about which he said the doctor was "fanatical." The second portrait, now in the Louvre, is similar to the one on this month's cover except Gachet's coat has no buttons and there are no books on the table. Vincent's descriptions of the portraits dwell mainly on his attempts to create color contrasts. He considered this portrait to be very "modern."

"The portrait shows a face the color of an overheated brick, scorched by the sun, with reddish hair and a white cap, a landscape of hills in the background. His hands, the hands of an obstetrician, are paler than the face."

During Vincent's two months in Auvers he did 150 sketches and oils, many of them his most famous works. His stay in Auvers ended tragically when he shot himself to death. Dr. Gachet, overcome with grief, delivered the eulogy at his funeral. Historians believe the books depicted in Dr. Gachet's portrait and the portrait itself went to Theo after Vincent's death.

The portrait on our cover is now part of a private collection in New York.

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Questions and Answers



Hormoz Rassekh, M.D.

AMA's 'retrospective analysis' of suicidal physicians

Is there a common profile for suicidal physicians? The author, a Council Bluffs psychiatrist, discusses results of a joint study by the AMA and the American Psychiatric Association.

In the late 1980s, the AMA and the American Psychiatric Association (APA) did a joint study on physician suicide. What prompted this effort?

The AMA was concerned about this issue because there is an erroneous impression there is more suicide among physicians. The AMA wanted to find out if there is anything which can be done to prevent physician suicide.

The AMA mandated the study and the APA played a major role. I was asked by the AMA to participate. I was the regional coordinator for several Midwestern states including Iowa. I helped interview people and collect data.

Why is there a public perception that physicians commit suicide more frequently than the general public?

Because of the prominence physicians have in the community, there is often much publicity when a physician chooses this permanent solution to temporary problems. Also, we keep better occupational data.

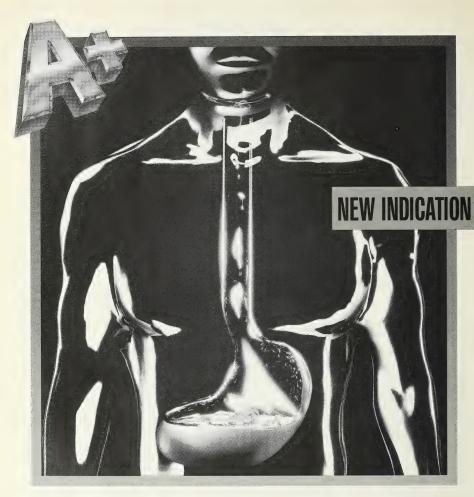
How was the AMA's study conducted?

The study was conducted regionally by a number of psychiatrists assigned to interview the families of deceased physicians, including physicians who committed suicide and those who died of natural causes. The goal was retrospective analysis of doctors who committed suicide, matching them with other physicians who died natural deaths to investigate any differences in the psychological profiles.

What were the major conclusions?

A clear profile of the suicidal physician emerged in contrast to physicians who died of natural causes. Most of the physicians who commit suicide have attempted it before and have a history of depression. They are far more prone to self-diagnose and self-prescribe than other physicians. Drug and alcohol abuse are far more common. These physicians are under more stress, are more critical of others, have

(Continued on page 69)



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year are not known.

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of gastic malignancy.

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150 mg b.t.d, was administered concurrently.

Carcinopensics, Muldepensics, Impairment of Fertility—A 2-year oral carcinopensicity study in rats with
doses as high as 500 mg/kg/day labout 80 times the recommended dayl herapoutic dose) showed no evidence
of a carcinopens effect. There was a obe-related increase in the density of entertrohomalifin-like (ECL) cells in the gastric oxyntic mucosa, in a 2-year study in mice, there was no evidence of a carcinopensic effect in makine, although typerplastic modules of the liver were increased in the high-dose makes as compared with
placebo. Fernale mice given the high dose of Axid (2.000 mg/kg/day, about 30 times the human dose) showed
marginally statistically significant increases in repeatic curcinoms and hepatic nortical hyperplass with no
numerical increase seen in any of the other lose groups. The rate of hepatic curcinoms in the high-dose
a dose larger than the maximum between the significant control and the control of the properties of of

a does larger than the maximum brieflated does, as indicated by excessive (30%) weight decrement as compared with concurrent control and evidence of a marginal finding at high does only an amainst give an an excessive and somewhat hepatotics does, with no evidence of a carcinopenic effect in rats, male mice, and entere the recommendation of the property of the control of the property of the control of the property of the prope

Adverse Reactions: Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference

between Axid and placebo in the incidence of any of these events (see package insert for complete information)

A variety of less common events were also reported; it was not possible to determine whether thes were caused by nizatidine

were caused by Nazalande in injury devotated fiver enzyme tests or alkaline phosphatose) possibly or probably in probably and the probably in SGOI or SGPT and, in a single instance, SGPT was > 2,000 U/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placeby patients. All abnormalities were reversible after discontinuation of Avid. Since market introduction, happing and probably in the probably in the probably in the probably in the probable of the proba

In places patents, All abordinates were reversited either decontinuation of Avidua decontinuatio

nausea related to nizatidine have been reported.

Overdosage: Overdosage occurs, activa

emesis, or lavage should be considered along with clinical monitoring and supportive threapy. The ability of headigysts to remove the contraction of the body has not been conclusively demonstrated; however, due to its large volume of institution, natidation and one of the finding the moved from the body by this method. PV 2093 AMP

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more financial problems and feel they are somehow different from others.

This profile—particularly the drug and alcohol abuse—illustrates the important role of the Society's Assistance Program for Troubled Physicians. This program is designed to spot these situations before they become unmanage-

Why are physicians more apt to diagnose and treat themselves?

Physicians face a greater potential stigma against seeking psychiatric care than members of the general population. This stigma is felt even if the physician is seeking help for a temporary problem such as death of a spouse. If a physician admits he or she has seen a psychiatrist on a licensing application, it can delay the licensing.

This is very unfortunate. Obviously, physicians will be resistant to treatment if seeking treatment has ramifications for their professional lives. I see quite a few physicians for depression and other problems and, although the treatment is no different for non-physicians, it is important to be sensitive to their special position in the community.

What role does the physician's family play?

Family members should be alert if they notice a physician becoming withdrawn, aloof and shows a lack of energy or change in professional behavior. It is very possible for a physician to be extremely depressed and no one notices. Temporary stress must not be confused with depression as a psychiatric illness.

Families of depressed and potentially suicidal physicians should realize they are not objective and will need professional help to deal with the problem. In Iowa, APTP provides a 24hour hotline service where families of troubled physicians can call an advocate on a highly confidential basis.

As the former chairman of the Iowa State Board of Medical Examiners and vice president of the Federation of State Medical Licensing Boards, what is your perspective on physician suicide?

I can't emphasize enough how important it is for the licensing boards and the Society's APTP program to collaborate on this problem. There is room for both organizations and there is a large segment of the physician population who need the expertise and involvement of one or both organizations.

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Non-A non-B hepatitis and hepatitis C virus

The author urges primary care physicians to assess their patients' risk of hepatitis and test those at risk.

Louis Katz, M.D.

Davenport, Iowa

A FTER IDENTIFICATION OF HEPATITIS A (HAV) and hepatitis B (HBV) viruses in the 1970s, it was apparent most hepatitis attributed to blood transfusion and many community acquired cases were caused by neither virus. Hence the designation non-A non-B hepatitis (NANB).

The Centers for Disease Control (CDC) sentinel county studies suggest NANB accounts for 25% of the recognized hepatitis in the U.S.¹ NANB is characterized by a long incubation (>2 months), by mild, often absent, clinical illness and high rates of progression to chronic hepatitis and cirrhosis. Seventy five percent of post transfusion NANB (PT-NANB) is anicteric and either asymptomatic or minimally so.

More than 50% of PT-NANB produces fluctuating elevations of hepatic transaminases for periods longer than 1-2 years, suggesting chronic infection.² Where chronic NANB patients have had liver biopsy, chronic active hepatitis was found in half and cirrhosis in 10% or more.³

Glossary of terms

HAV—hepatitis A virus
HBV—hepatitis B virus
NANB—Non-A non-B hepatitis
HCV—hepatitis C virus
Anti-HCV—antibodies to HCV
CA-NANB—community acquired NANB
PT-NANB—post transfusion NANB

Cirrhosis and chronic NANB

CDC data suggests the incidence of recognized NANB is 7.1/100,000/year. They estimate 170,000 new NANB infections/year in the U.S., with 17,000 cases of cirrhosis from chronic NANB. Evidence is growing of an association between chronic NANB and development of primary hepatocellular carcinoma.

In 1988, 42% of NANB cases were associated with IV drug use and 7% with heterosexual exposure to a partner with hepatitis or more than one heterosexual partner in the 6 months before their illness. Six percent of cases received blood products within 6 months of onset. Household contact with hepatitis patients, health care employment with frequent blood exposure, and hemodialysis were associated with 3%, 2% and 1% of cases respectively. No source was recognized for 34%.4

THE IOWA MEDICAL FOUNDATION HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION AWARD FOR FEBRUARY 1992

Dr. Katz is vice president of medical affairs for the Mississippi Valley Regional Blood Center in Davenport.

Infection attributed to IV drug use has increased markedly since the early 1980s. Post transfusion-NANB has declined coincident with donor deferral for HIV risk behaviors and surrogate testing using ALT (alanine aminotransferase) and anti-HBV core.

Other studies show less evidence of sexual or household transmission and these associations remain controversial. ⁵⁶ There are no data on the use of barrier contraception or other means to prevent community acquired NANB (CA-NANB), so there are no recommendations that patients make specific behavioral changes. Safer sex guidelines promulgated in the wake of the AIDS epidemic remain operative, regardless of the sexual transmissibility of CA-NANB.

Breakthrough in NANB study

The molecular biologic revolution produced a breakthrough in the study of NANB, culminating with the May 1990 FDA approval of a test for diagnostic use and blood donor screening detecting antibody to the most important cause of PT-NANB, hepatitis C virus (HCV).

In 1989, Houghton and colleagues at Chiron Corporation published elegant experiments describing an RNA virus implicated in most PT-NANB and CA-NANB cases. They cloned the genetic material of HCV and, using the resulting recombinant antigens, developed an assay for antibodies to HCV (anti-HCV). Six of 7 human sera known to transmit NANB to chimpanzees contained anti-HCV, while none of 5 sera from healthy controls did. Blood donors implicated in 10 cases of biopsy confirmed chronic active PT-NANB were studied; for 9 cases at least one seropositive donor was identified. All 10 recipients developed anti-HCV during their illness.

Other work has shown that from 60-90% of patients with chronic PT-NANB are seropositive. 9.10 Application of the HCV antibody test to stored samples from sporadic CA-NANB showed 45% of individuals tested within 6 weeks of the onset of hepatitis were seropositive. This increased to 68% of those with serum available from at least 6 months after onset. 4 There was no difference in the proportion with anti-HCV between the PT-NANB and CA-NANB cases. These data implicate HCV as the major cause of both PT and CA-NANB.

How effective is anti-HCV for donor screening, its major current use? From 0.5% to 1% of volunteer donors are seropositive using the screening test. 11 Studies using stored sera

from transfusion recipients who developed PT-NANB and their donors suggest in 60-90% of cases a donor with anti-HCV will be found. 9,10

In a Spanish study, 73% of PT-NANB patients (representing one-third of all cases of PT-NANB) who had received no blood from anti-HCV positive donors were shown to have hepatitis C seroconversion. This indicates test insensitivity. If these and other data are accurate

'Infection attributed to IV drug use has increased markedly since the early 1980s. Post transfusion-NANB has declined coincident with donor deferral for HIV risk behaviors and surrogate testing.'

and applicable to USA blood donors (after 8 years of AIDS screening and 5 years of surrogate NANB testing to prescreen the donor base), the likely reduction in PT-NANB incidence from before anti-HCV testing of whole blood donors (1-2% nationwide) will be about 50-80% (to 0.5-1% of transfusion episodes).¹²

Anti-HCV can disappear

What explains anti-HCV negative NANB? The current test may be intrinsically insensitive. Two thirds of hemophiliacs lacking anti-HCV in 1988 specimens were found to have prior seropositive samples from 1985; so it is possible anti-HCV can disappear in some infected individuals.¹³ This is suggested by the observation that anti-HCV disappears in acute resolving PT-NANB and by blood donor studies showing a decline in anti-HCV prevalence with increasing age.^{12,14}

Studies using the polymerase chain reaction to detect HCV genetic material found patients with chronic NANB had negative anti-HCV tests and substantial levels of HCV RNA in their livers.¹⁵ This suggests the current test underestimates the prevalence of HCV infection.

Other explanations must be considered. Seroconversion is often delayed several months and could be missed in recently infected patients or donors. ¹² Some seronegative cases may be non-viral, or there may be more than one virus (or HCV variant) associated

with NANB which remain undetected with current tests. 16,17

The specificity of anti-HCV testing is critical, especially with reference to its donor screening applications where a large group of low risk individuals may be subjected unnecessarily to evaluation for chronic liver disease if false positives are frequent. It is axiomatic that many reactive tests in a population with a low prevalence of infection (like blood donors) will likely be false positives. Unlike hepatitis B surface antigen, anti-HIV, anti-HTVL-I and the VDRL, no confirmatory test is available to validate the anti-HCV screen currently in use. Available data do not permit a quantitative estimate of the specificity or positive predictive value of a reactive anti-HCV. However, the strong association of anti-HCV positive blood donors with recipient PT-NANB suggests it will be reasonably high.

In Dutch blood donors between 1984 and 1986, 26% of anti-HCV positive blood products were associated with either biochemical PT-NANB or anti-HCV seroconversion in the recipient. Eighty-eight percent of recipients of an anti-HCV positive unit from Spanish donors developed anti-HCV positive PT-NANB and 100% seroconverted, suggesting a high positive predictive value of the system used. Description 12 California donors with reactive screens were positive on an investigational confirmatory

test.26

Evaluating blood donors

Evaluation of blood donors and others with serologic evidence of HCV infection should focus on clinical and laboratory evidence suggesting chronic inflammatory liver disease. This is accomplished by a history and physical examination followed by serial measurements of ALT (SGPT) and AST (SGOT) at intervals over 12-18 months. Imaging procedures (CT, ultrasound, radionuclide) have limited application to this group of patients and should rarely be used.

Those with evidence of chronic liver inflammation at the completion of this biochemical evaluation can be considered for liver biopsy based on a need for histologic information and the current status of therapy. Supplemental HCV testing, when available, will allow increasing precision in the recommendations given to patients or donors with reactive anti-HCV screening tests and intermittently or persistently abnormal hepatocellular enzymes.

The frequency of HCV infection, its tendency to chronicity and association with cirrhosis and hepatocellular carcinoma, underscore its importance. There is evidence interferon therapy may alter the natural history of HCVassociated chronic active hepatitis. 19 Recent studies with short term follow-up allow the following generalizations. Many patients with chronic hepatitis and evidence of HCV infection who are given a variety of alpha-2 interferon regimens will respond with normalization of abnormal liver function studies. 20-24 From 10-50% of treated individuals will have a sustained complete response at 3-12 months after therapy, with the lowest remission rates reflecting the longest follow-up.26

In light of this, interferon treatment of chronic active HCV infection should be considered investigational, despite FDA approval for the indication. Important questions remain. Do normal liver enzymes translate into sustained improvement of histology or a decrease or delay in progression to cirrhosis? Is there an effect on risk for hepatoma? Which histologic subsets of liver disease will respond? Is infectivity abolished with normalization of liver enzymes? If the short term treatments and doses employed produce modest effects, will higher doses and/or longer durations produce lasting effects of

greater magnitude?

Identification of HCV is a landmark in our understanding of viral hepatitis. Critical work remains—description of the routes of transmission of CA-NANB and application of that data to prevention; development of more accurate screening and confirmatory tests to increase diagnostic and prognostic accuracy, as well as to identify candidates for treatment if useful; identification of HCV variants or distinct hepatitis viruses (such as hepatitis E virus) responsible for NANB not explained by current tests; and demonstration of the utility of interferon or other anti viral agents.

With the description of this pathogen and the potential availability of treatment, it is of paramount importance that primary care physicians assess their patients' risk of hepatitis and test those found to have been transfused or to have engaged in behaviors associated with HCV infection.

References

References noted in this article are available from the authors or the editors of IOWA MEDI-CINE.

Radio-frequency catheter ablation for cardiac arrhythmias

Catheter-delivery of radio-frequency energy has emerged as a safe and very effective non-medical therapy for common supraventricular arrhythmias.

James Hopson, M.D. Michael Kienzle, M.D.

Iowa City

DESPITE IMPROVEMENTS in drugs available for management of cardiac rhythm disturbances, many patients require an alternate form of therapy, either because of a lack of efficacy or an inability to tolerate effective medication.

The structural origins of most clinical arrhythmias can be identified during invasive electrophysiologic testing. Catheter ablation techniques appear to offer an attractive alternative to cardiac surgery in the selective destruction or removal of tissue responsible for the arrhythmia.

Catheter ablation using direct current (DC) shocks delivered by electrode catheters to an endocardial site of arrhythmia origin has been utilized over the past decade to treat both supraventricular and ventricular arrhythmias. The ablative effects of catheter-delivered DC energy on cardiac tissue result from a combination of heat, barotrauma and intense local electrical field generated at the catheter tip.

Widespread acceptance and utilization of the technique has been limited by several problems, including difficulties in controlling lesion size, inability to safely employ the technique in left-sided accessory A-V connections, low rates of success for ventricular arrhythmias and occasional hemodynamic intolerance to ablative shocks. Application of the technique requires general sedation similar to that employed for cardioversion.

Although radio frequency (RF) energy has long been used for both neurosurgical and dermatologic surgery applications, it only recently has been recognized for its potential use in cardiology and in the treatment of cardiac arrhythmias. Over the past several years considerable experience has been gained in the application of catheter-delivered RF energy for treatment of both supraventricular and ventricular arrhythmias.

Radiofrequency energy

RF energy, with frequencies between 150 to 1000 kHz, is a form of alternating electrical current that has varying effects on biologic tissue depending upon the power output and characteristics of the delivered energy. RF energy can be used for electrosurgical cutting or fulguration as in surgical applications, or electrical desiccations as desired in the therapy of cardiac arrhythmias.

Because of the physical properties of this energy form, there is no explosion or gas-bubble formation at the catheter tip, internal electrical arcing does not occur and discrete lesions are created of spherical or oval shape. Anesthe-

Dr. Hopson is an assistant professor and Dr. Kienzle is an associate professor with the Department of Internal Medicine, University of Iowa Hospitals and Clinics.

sia (general or otherwise) is typically not required, as most patients are not aware of RF energy being applied and very few experience actual discomfort.

The size of RF energy-created lesions vary directly with the amount of energy delivered and the duration of the application, as demonstrated by Wittkampf et al. in Figure 1.¹ In general, myocardial lesions created using RF energy are smaller than those produced by DC energy and their size is more easily regulated.² Histologic examination of RF lesions reveals a well-delineated spherically-shaped area of necrosis surrounded by a small hemorrhagic border, which over weeks to months is replaced by focal fibrosis. The endocardium is typically not disrupted. A comparison between RF and DC energies as relevant to ablative therapy can be seen in Table 1.

In patients, RF energy is applied to the heart with a transvenous electrode catheter, whose distal tip has been placed adjacent to cardiac tissue identified at electrophysiologic study as being necessary to genesis or propagation of the arrhythmia. Energy is applied in unipolar fashion between the distal electrode and a large cutaneous skin electrode. The energy requirements range from several hundred to several thousand joules, using from one to 10 or more separate applications of energy.

An electrode catheter with a tip modified to have a greatly increased surface area is essential, as this helps prevent excessive heat generation at the catheter-tissue interface and thus avoids formation of coagulation debris on the catheter tip. Other than these modified electrode catheters and the RF generator itself, no additional specialized equipment is required beyond that already present in a laboratory performing invasive electrophysiologic studies.

Clinical application

This technique has found the greatest success thus far in ablation of atrio-ventricular accessory pathways (Kent bundles) that mediate arrhythmias in WPW syndrome and selective ablation of one or more AV nodal structures involved in AV nodal reentry SVT. Ablative approaches to ventricular tachycardia have been limited and have been less successful. There has also been extremely limited experience in the use of RF energy to ablate atrial tissue responsible for ectopic atrial tachycardias.

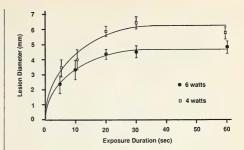


Figure 1. Radiofrequency lesion size as a function of energy and time of exposure. (Modified from Wittkampf, et al. ¹)

TABLE 1

COMPARISON OF DIRECT CURRENT VERSUS
RADIOFREQUENCY CURRENT FOR CATHETER ABLATION
(ADAPTED FROM HUANG')

	Direct current	RF current
Waveform	Monophasic dampened sinusoidal	Continuous unmodulated sinusoidal
Peak voltage	1000-3000 V	< 100 V
Barotrauma	Yes	No
Electrical arcing	Yes	No
General anesthesia	Yes	No
Arrhythmogenicity Hemodynamic	High	Low
seguelae	Frequent	Rare
Catheter damage	Frequent	Rare
Energy control	Less possible	Possible
Lesion histology	Inhomogeneous with irregular and wide margins	Homogeneous with sharp and narrow margins
Lesion size	Larger and difficult to control	Smaller and easier to control

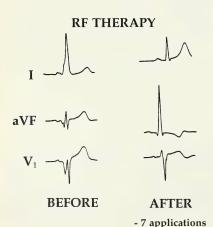
For patients with WPW syndrome, the technical aspects of AV accessory connection ablation are remarkably uniform among the various centers offering this form of therapy, as have been the results reported thus far in the literature. 46 Both right and left sided accessory pathways, multiple pathways and concealed pathways can be ablated in the first attempt in about 80-85% of cases. Repeated attempts are often successful if ablation is not initially possible.

There appear to be no hemodynamic or significant structural sequelae of the procedure, and the procedure seems to be relatively safe,

(Continued next page)

with risks similar in type and frequency to those expected for diagnostic right and leftheart catheterization. In a case performed at the University of Iowa, Figure 2 demonstrates the electrocardiographic results of a successful RF ablation of a right-sided AV accessory pathway in a young man with recurrent SVT poorly responsive to medications. The tracing following RF energy application shows loss of ventricular preexcitation. The accessory pathway was found to be ablated on more thorough electrophysiologic testing. This patient has been without recurrent SVT in follow-up.

The most common mechanism of paroxysmal SVT is AV nodal reentry, and there has been considerable interest in finding a safe and effective non-medical option for patients with this rhythm disturbance. The "fast" and "slow" pathways involved in AV nodal reentry SVT are structurally distinct elements that, although adjacent, can be independently targeted for RF ablation. Ablation of either pathway results in interruption of the arrhythmia. Successful therapy with RF energy can be expected in approximately 80% of cases regardless of the approach used.⁷ The chief risk of energy application in the vicinity of the AV



- 4733 joules total Figure 2. Effects of RF therapy on ECG evidence of preexcitation in an 18-year-old patient with a right postero-septal

accessory pathway.

- 50 volts each - 18-30 seconds

'Anesthesia is typically not required, as most patients are not aware of RF energy being applied and very few experience actual discomfort '

node is the production of complete heart block (CHB), the incidence of which varies between 1 and 8%.

The risk of CHB is lower in "slow" pathway-directed approaches, as this structure is more geographically removed from the main body of the AV node and His bundle. In some patients with medically refractory atrial fibrillation or flutter, CHB is the intended result of RF therapy. This can be achieved in 80-90% of cases. In this latter application, implantation of a permanent pacer implant either precedes or follows the RF therapy.

Summary

Catheter-delivery of radiofrequency energy has rapidly emerged as a safe and remarkably effective form of non-medical therapy for several types of common supraventricular arrhythmias. For patients experiencing arrhythmias that utilize an AV accessory connection, RF ablation may soon emerge as first line therapy and the treatment of choice.6

Although further studies are needed to document the long-term safety of this procedure, the experience to date is extremely promising. A challenge for the future is to refine the technique so it may be applied to patients with ventricular arrhythmias, a patient group in whom additional therapeutic options are badly needed.

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A physician's mind is not for sale

Richard P. Nelson, M.D.

THE PRACTICE OF MEDICINE is under constant scrutiny from our peers, by insurers and by public agencies. How physicians acquire new knowledge and learn skills while in practice is also in the public eye.

The objectivity of continuing medical education has been brought to task by critics because some CME events have been financially supported by commercial organizations that veil the marketing of a medication or product in the guise of continuing education. An often cited example of this practice is the dinner-lecture to which physicians are invited at no cost (or even receiving a fee to attend) that features an expert speaker expounding the clinical usefulness of a product which the sponsoring organization manufactures

Similarly arranged CME offerings have been developed in more elaborate settings, in effect subsidizing physician registrant vacations, and providing substantial, tangible gifts.

An outcome of these revelations has been the revision of guidelines for the commercial support of continuing medical education. These guidelines were approved in March of 1991 by the Accreditation Council for Continuing Medical Education, the entity that accredits our University of Iowa College of Medicine to award Category 1 CME credit.

- Accredited sponsors (such as universities and hospitals, and not commercial organizations) must be responsible for the content, quality and scientific integrity of all CME activities.
- Accredited sponsors are responsible for the enduring materials (workbooks, handouts) used in CME activities.
- Presentations must give a balanced view of all therapeutic options, especially

when there are identical or similar products available from different manufacturers.

- Commercial exhibitors should not interfere with CME activity, or be a condition of support for the activity.
- Funding arrangements are the responsibility of the accredited sponsor, with funds from a commercial source in the form of an educational grant to the sponsor.
- Commercially supported social events at CME activities should not take precedence over educational events.
- An accredited sponsor should have a policy on conflict of interest, and
- Travel, lodging, honoraria or personal expense reimbursement for attendees is not permissible.

The Office of Continuing Medical Education at the University of Iowa follows these guidelines for all events we sponsor or cosponsor with a community program. We have recently become aware of a concept paper developed by the federal Food and Drug Administration that is likely to further stimulate interest in the issue.

This paper, "Regulation of Drug Company-Sponsored Activities in Scientific or Educational Contexts," states "promotion through scientific and educational programs is of particular concern to FDA because of its capacity to inject bias into ostensibly objective programs and publications, because the promotional nature of these programs is often undisclosed and because promotional activities in scientific and educational programs are not being reported to FDA under the reporting requirements applicable to advertising and promotional labeling." While the intended activism of the FDA in this arena is being challenged by the manufacturers and their agents, it appears clear that additional scrutiny is inevitable.

Public confidence in physician practice will be bolstered by vigorous efforts to maintain (or restore) the objectivity of our continuing education.

Dr. Nelson is associate dean for continuing medical education at the University of Iowa College of Medicine.

IFMC bylaws changes

ANY IOWA PHYSICIANS KNOW of the IFMC's role as the peer review organization (PRO) for Iowa and Nebraska, but they are surprised to learn the IFMC is now a diverse health management services company with capabilities beyond the PRO program. The IFMC and its subsidiary operate multiple review sites in five states and have expanded review activities to serve hundreds of private business clients nationwide. Its information systems division provides data processing support to 15 PROs, handling more than 1.5 million discharges annually. The IFMC employs more than 350 staff and has an operating budget of almost \$20 million.

Proposed changes

For some months, the IFMC Board of Directors has been considering changes in its board structure to better serve the IFMC's diverse structure and enable its continued growth. The revisions streamline operation of the IFMC board, enabling it to be more responsive and update the IFMC's articles and bylaws to reflect current business operations. Changes under consideration include:

- 1. Decreasing—through attrition—the number of director positions from 40 to 20. Four of the 20 positions would be elected by the physician membership. Of the 20 positions, at least 70% would be physicians. At least 80% of the physician directors would be Iowa physicians. (The balance would provide representation to Nebraska physicians, since the IFMC also holds the PRO contract in Nebraska.)
- 2. Electing 20% of the physician members of the board by the membership. The remain-

der would be elected by the board. To the greatest extent practical, the board would be required to maintain appropriate representation from allopathic and osteopathic physician constituencies. Also, regional representation from the state will be maintained.

- 3. Electing board members for three-year terms with unlimited terms.
- 4. Enabling future changes in bylaws to be made by vote of the IFMC Board of Directors; continuing the requirement that the IFMC physician membership approve changes to articles of incorporation.
- Updating bylaw descriptions of the executive, comprehensive review, long-term care and quality assessment committees.

These changes must be approved by ballot vote of the IFMC's physician members.

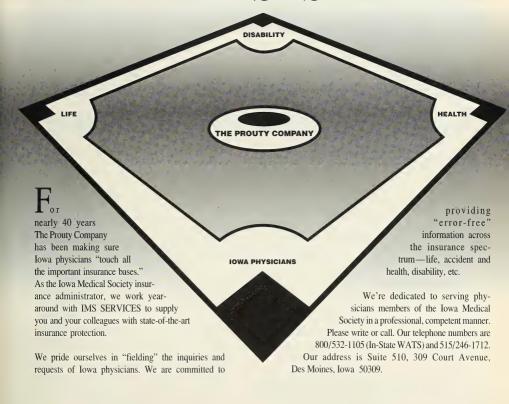
From its founding to the present, the IFMC has evolved to meet the challenge of its purpose: To develop, promote and encourage the distribution of quality medical services to those served at an equitable cost and in appropriate quantity.

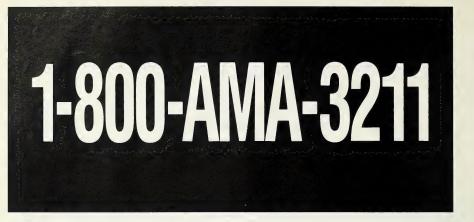
The changes currently proposed are designed to encourage smooth operation of a dynamic health management organization committed to the concepts of professional peer review and continued working relationships with Iowa physicians who share our mission.

(Addendum: At their December meeting, IFMC directors amended their proposal to include a director tenure limit of 12 years. All Iowa physicians will receive more detailed information regarding these changes by mail in the upcoming weeks.)

This article is provided by the Iowa Foundation for Medical Care.

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Setting Iowa's health agenda

We began the 20th Century with a sense of fatalism about the nation's health problems, but we are ending it with confidence in our ability to control our destiny. However, the same sophisticated techniques and technologies that have minimized health risks have also created a crushing financial burden that is threatening our health care system.

One of the most important issues to emerge in the 90s is the role of prevention in containing health care costs. Over 75% of national health care costs are the result of diseases or injuries that are preventable. In fact, nine preventable chronic diseases are responsible for over 50% of all deaths in the United States.

In addition, two out of three deaths and one out of three hospitalizations are attributed to a life-style risk that is linked to rising health care costs. Costly life-style risks include the use and abuse of tobacco, alcohol and other drugs; preventable injuries; high blood pressure; diet; and lack of preventive health care. For example, smoking-related health costs in Iowa are estimated at \$146 per person, while estimated total substance abuse costs in Iowa are more than \$700 million per year.

While studies show that Iowans are aware of these risks, a vast difference exists between their current life-styles and actual behavior changes. It is becoming increasingly evident, therefore, that individuals will change only

when societal attitudes change.

A framework for such societal change is already in place at the national level. The Healthy People 2000 National Health Promotion and Disease Prevention Objectives represents three years of work by a consortium of almost 300 organizations under the leadership of the Institute of Medicine and the Public Health Service. Nearly 300 specific measurable objectives in 22 priority areas were designed to prolong healthy life spans, ensure equality in health status among all races and ethnic groups and ensure access to preventive health services.

A similar framework is under construction in Iowa. The Healthy Iowans Task Force, appointed in 1990 by Governor Branstad, is charged with developing a plan to promote health and prevent disease and injury in Iowa. Richard D. Remington, Ph.D. is chairman of the task force. Dr. Remington is a distinguished professor of preventive medicine and director of the Institute for Health, Behavior and Environmental Quality at the University of Iowa.

In addition to the Task Force, over 70 professional, voluntary and business organizations have agreed to participate in planning and implementing the Healthy People 2000 plan. The task force will present a draft plan at public hearings around the state during May

and June of 1992.

Once the plan is completed, it will shape program priorities and influence federal funding proposals and state budget requests during the 1990s. The Iowa Department of Public Health is currently integrating all its planning efforts into the Healthy Iowans 2000 Plan.

For more information about Healthy Iowans 2000, contact the Iowa Department of Public Health at 515 (281,5787)

Public Health at 515/281-5787.

National priorities addressed in Iowa's plan are:

- Health Promotion—physical activity and fitness, nutrition, tobacco, alcohol and other drugs, family planning, mental health and mental disorders, violent and abusive behavior and educational and community based programs.
- Health Protection—unintentional injuries, occupational safety and health, environmental health, food and drug safety and oral health.
- Preventive Services—maternal and infant health, heart disease and stroke, cancer, diabetes and chronic disabling conditions, HIV infection, sexually transmitted diseases, immunizations and infectious diseases and clinical preventive services.
 - Surveillance and Data Systems.

This material is furnished by the Iowa Department of Public Health.

Caring For Iowans For More Than 50 Years.

The changes in health care and health coverage in the last five decades have been tremendous. And, through it all, Blue Cross and Blue Shield of Iowa has helped set the pace.

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College of Medicine Highlights

YOU'RE NEVER TOO OLD to reap the benefits of kicking the cigarette habit, confirms a study of 7,200 people aged 65 and older. "People who quit smoking, even if they're over the age of 65, can reduce their risk of dying from cardiovascular disease to the level of those who have never smoked, regardless of when they quit," said Dr. Robert Wallace, preventive medicine and environmental health. While the ill effects of smoking on cardiovascular health drop dramatically after quitting, the effects on cancer are thought to depend on accumulated exposure and diminish more gradually. The study, supported by the National Institute on Aging, involved researchers from the UI; Brigham and Women's Hospital, Boston and Yale University, New Haven, Connecticut.

RESEARCH CONTINUES TO REFINE the use of the laser in treatment of macular degeneration, the most common cause of severe vision loss in Americans over age 55. In the September 15 issue of Archives of Ophthalmology, UI researchers reported that laser therapy can be used successfully to destroy abnormal blood vessels that have grown in the fovea, the part of the retina that allows people to see small details. "By showing the benefit of laser treatment for this very sensitive portion of the eye, we are able to save as much retina around it as possible, halting the loss associated with the growth of new vessels," said Dr. Alan Kimura, ophthalmology. Other study investigators were Drs. James Folk and Edwin Stone, both of ophthalmology. The UI is one of 13 centers participating in the Macular Photocoagulation Study, a project that is evaluating the use of lasers to treat the agerelated disease.

A RESEARCH PROJECT AT THE UI may help explain the process by which a body becomes acclimated to warmer temperatures. A family of cellular proteins called "heat shock" proteins can be produced in people exercising in the heat at non-lethal body temperatures,

reported **Drs. Pope Moseley** and **Carl Gisolfi, physiology** and **exercise science.** Moseley, Gisolfi and graduate student Alan J. Ryan published these findings in the January 1991 issue of the *Journal of Applied Physiology*. The National Institutes of Health has awarded Moseley a \$819,000 grant to study whether the process of producing heat shock proteins at the cellular level affects the entire body's tolerance of heat stress.

ABOUT ONE IN 5 PATIENTS WHO UNDERGO cardiopulmonary bypass (CPB) has a detectable decrease in how "crisply" he or she can think, said Dr. Bradley Hindman, anesthesia. Hindman has been awarded a \$600,000 grant from the National Institutes of Health to determine ways to conduct CPB during surgery that lessen adverse effects on the brain. Other UI anesthesia faculty participating in the study are Drs. John Tinker, Michael Todd, David Warner and Jeanette Harrington.

SEAN MURPHY, PHARMACOLOGY, WAS AWARDED a \$300,000 grant from the National Institutes of Health to study the function of astrocytes, specialized cells in the brain that release vasoactive chemicals that affect the diameter of blood vessels. UI pharmacology researchers recently discovered one of the chemicals released from astrocytes can relax vessels and is similar to nitric oxide. Discovering how its production is regulated may be important in understanding how damage caused by trauma of strokes affects the brain.

DR. SAMUEL FOMON, PEDIATRICS, HAS WON 2 grants to study infant nutrition. The Division of Maternal and Child Health of the U.S. Public Health Service awarded Fomon \$498,000 to study iron absorption from iron-fortified infant formulas. Dr. Kenneth Lombard, pediatrics, is also an investigator in that study. Fomon also received \$97,000 from the U.S. Department of Agriculture to examine the effects on infants of fluoride given in different ways, such as in formulas or supplements.

This material is furnished by the U. of I. Health News Service.

About Iowa Physicians

Items in this column are compiled from newspaper clippings from the Iowa Press Clipping Bureau. News from individual physicians, clinics and hospitals is welcomed and encouraged.

Dr. C. Patrick Burns, professor of internal medicine and director of the division of hematology-oncology at the U. of I. College of Medicine, was recently appointed to the American Board of Internal Medicine's Subspecialty Board on Hematology. Dr. Don Boyle, Sioux City, has been named to the National Committee on Trauma by the American College of Surgeons. Dr. Boyle is a general surgeon with Siouxland Surgical Associates, P.C. and is an assistant clinical professor of surgery at the U. of I. College of Medicine. Dr. G. Frank Judisch and Dr. Jeffrey Nerad, professors in the ophthalmology department at the U. of I. College of Medicine, have received the Honor Award by the American Academy of Ophthalmology. The award, given in Anaheim, California, recognizes ophthalmologists who have made significant contributions to their specialty through scientific presentations, teaching academy instruction courses and/or participating in the development of academy educational programs. Dr. Mark Duff, Park Clinic pediatrician, Mason City, has been appointed director of the nursery intensive care unit at St. Joseph Mercy Hospital. Dr. Duff practices with Dr. Leah Willson and Dr. Russell Smidt. Dr. Bill Withers has retired after practicing medicine at the Waukon Medical Clinic for 30 years. Dr. Withers received the M.D. degree from the University of Colorado School of Medicine, Denver, Colorado and interned at Denver General Hospital. Dr. Clarence Douglas has retired after practicing medicine in Belle Plaine for 33 years. Dr. Douglas received the M.D. degree from Meharry Medical College, Nashville, Tennessee and completed an internship at Mercy Hospital, Cedar Rapids. Dr. William Jackson has been named medical director of the Trinity Regional Hospital Emergency Department, Fort Dodge. Dr. Kenneth Olson has joined the Waukon Medical Clinic. Dr. Olson received the M.D. degree from the University of Colorado School of Medicine, Denver, Colorado and served his residency at Mercy Hospital and St. Luke's Hospital, Cedar Rapids. Dr. Olson practiced in Waukon from 1975-81, then was in private practice in Bemidji, Minnesota. Dr. Gary Fanning has left his anesthesiology practice with the McFarland Clinic in Ames for a practice in Illinois. Dr. Fanning also served as medical director for the ambulance service at Mary Greeley Medical Center, Ames. Dr. Kathleen Massop has joined the practice of Dr. Linda Railsback and Dr. Barbara Beatty, Des Moines. Dr. Massop received the M.D. degree from Creighton University School of Medicine, Omaha, Nebraska and completed her obstetrics/gynecology residency there also. Prior to locating in Des Moines, Dr. Massop practiced in Omaha, Nebraska and Columbus, Ohio. Dr. Robert Brainerd of the Family Medical Group in Lake Mills has resigned as deputy medical examiner for Winnebago County. Dr. Brainerd held the position for 22 years. Dr. Clarence Carlson, also of the Family Medical Group has been appointed to replace Dr. Brainerd. Dr. Carl Schultz, Mercy Emergency Department, Davenport, was recently awarded fellowship in the American College of Emergency Physicians. The following physicians have been named a diplomate of the American Board of Family Practice: Dr. Nicholas Messamer, Oskaloosa; Dr. Thomas Babcock, Jefferson; Dr. Joan Collins, Iowa City; Dr. William Daft, West Burlington; and Dr. Douglas Miedema, Sibley.

Deaths

Dr. DeWayne Anderson, 72, Stanhope, died December 8 at Mary Greeley Medical Center, Ames. Dr. Anderson received the M.D. degree from Washington University School of Medicine, St. Louis, Missouri and served internships at City Hospital and Lutheran Hospital, both

in St. Louis. He practiced in Stanhope for 23 years before joining the McFarland Clinic in Ames where he practiced for 14 years, retiring in 1985.

Dr. Virginia Moldenhauer, 61, Marengo, died December 13 at Mercy Medical Center, Cedar Rapids. Dr. Moldenhauer received the M.D. degree from Howard University Medical School, Washington D.C. and served a residency at Mercy Hospital, Chicago, Illinois. She remained at Mercy Hospital for 10 years prior to locating in Marengo where she was in private practice for 20 years before retiring in 1990.

Dr. Burdette Osten, 79, died November 28 at his home. Dr. Osten received the M.D. degree from the U. of I. College of Medicine and completed an internship in Fort Wayne, Indiana. Dr. Osten practiced in Northwood for 52 years and was a life member of the Iowa Medical Society.



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FAMILY PRACTICE, DEWITT, IOWA — (20 miles north of Davenport, Iowa). BC/BE FP needed to take over a practice on June 1, 1992. Well established practice. Guaranteed salary. Jim Ragland, Administrator, DeWitt Community Hospital, 1118 11th Street, DeWitt, Iowa 52742; 319 (59-3241.

EASTERN IOWA, FAMILY PRACTICE — Vinton is located in the heart of the lowa City-Cedar Rapids-Waterloo corridor, just 11 miles from L-380. Our 3-person family practice is expanding to 5. Call is shared equally. On weekends and most holidays, ER coverage is provided by the hospital. The clinic, redecorated in 1990, is adjacent to the hospital. We receive outstanding support from the local hospital and referral center in Cedar Rapids. We are seeking BE/BC family physicians who desire a rural life-style and practice, yet would enjoy easy access to Cedar Rapids and Iowa City. Send resume, in confidence, or call: Sandy Schipper, Director of Practice Operations, STL Health Resources, Cedar Rapids, Sewa 52403, phone 319/369-8021.

CHARITON, IOWA — Weekend coverage available in low volume ED at this progressive 56-bed hospital. Weekday coverage and developing weeknight coverage in future. Part-time openings can evolve into rewarding full-time opportunity. Democratic group, excellent compensation, paid malpractice insurance with unlimited tail coverage and full benefit package to full-time staff. License reimbursement for out-of-state physicians. Other locations currently available. Contact Acute Care, Inc., P.O. Box 515, Ankeny, Iowa 50021; 1-800/729-7813.

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DES MOINES 50309 515/283-5767 DISEASES AND SURGERY OF THE COLON AND RECTUM

For physicians in trouble, help is a phone call away

EXPERTS MAY DISAGREE ABOUT the exact nature of the cause-and-effect relationship, but the end result is irrefutable. Abuse of alcohol and other drugs is more common among suicidal physicians than among other physicians.

As described in this month's "Questions and Answers" article, the American Medical Association conducted a study of physicians who committed suicide, comparing them with physicians who died of natural causes. According to the study results published in *JAMA*, the greatest difference between the two groups lay in their use of drugs and alcohol.

Based on post-mortem interviews with family members and friends, over one third of the physicians who committed suicide were believed to have had a drug problem at some time in their lives. The corresponding figure for physicians dying of natural causes was 14%. Also, physicians committing suicide were reported to have had more social problems caused by drinking.

And, not surprisingly, these drug and alcohol problems were more prevalent in the last two years of life for physicians committing suicide.

Obviously, there is a need for programs such as the IMS Assistance Program for Troubled Physicians (APTP). APTP has been built on the premise that early intervention is essential to help physicians who are depressed or abusing alcohol or drugs.

Through the program, physicians provide assistance to their colleagues before these problems become severe enough to cause impairment. In the case of suicidal physicians, early intervention is even more critical.

When APTP is contacted by a concerned colleague, family member or friend regarding a possible troubled physician, physician advocates are assigned to work with the physician to determine if a problem exists which may lead to impairment of the physician's skill. When it's appropriate, they encourage participation in treatment and provide support during the recovery process. (Contact APTP by calling IMS headquarters, 515/223-1401 or 800/747-3070. All calls are confidential.)

Today, society is much more aware of the troubled physician and the early warning signs of more severe problems. Such awareness is good if physicians are to be helped at the earliest possible time. Members of the committee stress that contacting APTP is not tantamount to reporting a physician to the Iowa Board of Medical Examiners.

The IMS has not forgotten the family members of troubled physicians—people who may need help coping with the pervasive problems of the physician. In conjunction with APTP, the IMS Auxiliary has established "Helpline." Family members of troubled physicians can call Helpline for assistance from an Auxiliary member who has also experienced substance abuse by a loved one.

This month, the IMS organized the second Conference for Impaired Professionals, assisted by professional associations representing dentists, nurses, pharmacists, veterinarians and others. The extremely successful conference is another giant step toward finding the most effective ways to help impaired professionals.

Meanwhile, for physicians suffering the effects of depression or substance abuse, help is only a phone call away.

Maybe you think it's OK to practice in Iowa without one of these.



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The recommended starting dose for Calan SR is 180 mg once daily. Dose titration will be required in some patients to achieve blood pressure control.

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Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

RRIFE SUMMARY

Contraindications: Severe LV dysfunction (see Warnings), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory

bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eq. ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rddegree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with veranamil

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressurelowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°,2°,3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence. 4/11/91 • P91CA6277V

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<u>lowaMedicine</u>

March 1992 Journal of the Iowa Medical Society

Data on 26 lowa hospitals released to public this month—page 105



"Call me Doc"

Two physicians extol the joys of practicing and living in rural lowa

- Farm Bureau president concerned about primary care shortage
- Latest medical manpower data from the U of I

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There is no "safe" level of lead exposure for lowa children exposed to deteriorating paint in pre-1970 housing.

Douglas Weismann, M.D.

About the Cover

"Autumn Sunset" is the name of the lovely photograph by Douglas Olk, M.D. which graces this month's cover. Dr. Olk, a Dubuque pediatrician, took this photograph on an abandoned farm outside Dubuque. Dr. Olk took the photograph to fulfill an assignment in photography class and says people—particularly children—are his favorite subjects.



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Registration

Keynote Speakers

James R. Pluth, M.D. Michael B. Hill, M.D., F.A.C.E.P.

Course Objectives and Intended Audience —

This course is designed to provide family practitioners, internists, other primary care physicians and nurses with practical approaches to common cardiovascular disorders. The course will emphasize diagnostic evaluation, treatment modalities and day-to-day management of these disorders from the perspective of the primary care physician.

- Agenda -

Opening Remarks - Dr. James Levett

8:15	Surgical challenges in the treatment of coronary artery
	disease - Dr. James Pluth
9:00	Controversies in the management of silent ischemia
	- Dr. Eric Deanfield
9:45	Question Session
10:15	Break
10:30	The current role of nuclear testing in the evaluation of the
	cardiac patient - Dr. John Floyd
11:15	Identification of the young patient at risk for sudden cardia
	death - Dr. Bruce Waller
12:00	Question Session
12:30	Lunch
	Perspectives on medical practice in the Soviet Union
	- Dr. William Meffert
1:30	Update on the National Heart Attack Risk Study - Maurita
	Soukup, RN, CCRN, D.N.SC.

Concurrent Workshops

Failure to diagnose acute myocardial infarction -

- 2:30 Auscultation of heart sounds Dr. Clarence Shub and Dr. John Stokes
 - Legal issues case presentations Dr. Michael Hill
- New cardiac medications -Which drug for your patient - Dr. Lawrence Cook

Legal issues - Dr. Michael Hill

- 3:15 Break 3:30 - Auscultation of heart sounds - Dr. Clarence Shub
 - and Dr. John Stokes

 Medical case studies Dr. A. Ersin Atay
 Codical passing in the Od's Linda Mayiby BN
- Cardiac pacing in the 90's Linda Mavity, RN 4:15 Evaluations

- Accreditation -

CME: As an organization accredited by the lowa Medical Society for continuing medical education, the Cedar Rapids Medical Education Program certifies that this CME offering meets the criteria for 8 Credit Hours in Category 1, provided it is used and completed as designated.

American Academy of Family Physicians: Credit hours for the American Academy of Family Physicians has been applied for.

American Osteopathic Association guidelines for continuing medical education has indicated that this program is eligible for 7 credit hour(s) in Category 2-A.

Risk Management: The two presentations by Dr. Michael Hill have been approved for 2 hours of risk management credit towards lowa Physicians Mutual Insurance Trust's educational requirement.

CEU: 0.8 CEUs will be awarded upon full completion of the program by St. Luke's Hospital, Provider #46. The program meets criteria for the lowa Board of Nursing Subject Matter 5.3 (2) a (1, 2, 3, & 5). The cost for CEUs is included in the conference fee. Certificates will be awarded at completion of the program. For questions or further information regarding CEU processing or grievance policies contact Sandra D. Vanourny at St. Luke's Hospital, 319-369-7500.

Registration Fee

Physician—\$50.00 Residents & Nurses—25.00 (includes course materials, breakfast, lunch and refreshments)

Registration Deadline is May 1, 1992. Registration is limited. For registration information please contact June Zenisek, R.N., Symposium Coordinator, 319-362-5118 or 1-800-728-5118

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R. Bruce Trimble, M.D.

Rural medicine

MOST OF US EITHER PRACTICE in rural areas or draw from a rural patient base. The topic of rural medicine is a central one for the Iowa Medical Society.

Expansion of public health service programs, improvement of Medicare reimbursement for rural physicians and similar specific programs are important, but it is also worthwhile to step back for a larger perspective.

The shortage of rural physicians stems in large part from the shortage of primary care physicians. Only about 20% of medical school seniors now plan to go into primary care specialties. In other countries — and in HMOs in this country — 50% or more of physicians are in primary care. What are the implications for cost, efficiency and ready availability of medical care? What is the optimal specialty mix? How should it be determined and implemented?

Rapidly and widely, Iowa's rural physicians and hospitals are affiliating in various formal and informal ways with each other

and with hospitals and physician groups in larger towns. This parallels trends in urban areas and anticipates calls by many health planners for development of unified delivery systems. What are the issues of control, adminstration and potential shift of physician obligation from patient to institution?

The question of what resources — primary care, specialty, hospital, high-tech equipment — should reasonably be provided in small towns is really a part of the larger societal question of how to balance demand, quality and convenience against cost.

Clearly, we must deal with immediate problems. But rural medicine may also provide some lessons as the debate advances on reform of the health care system.

This column seems to have been a litany of problems and challenges. Perhaps that's just life. Eighteen hundred years ago, Marcus Aurelieus concluded "the art of living is more like wrestling than dancing." Those words still apply today.

W"c.

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CANCER UPDATE: CURRENT AND FUTURE PERSPECTIVES"

APRIL 8, 1992

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The Editor Comments



Marion E. Alberts, M.D.

Agricultural Environment

INASMUCH AS THE GENERAL THEME of this issue of *IOWA MEDICINE* is rural medicine, it seems appropriate to comment on two books that recently came to my attention.

Health Hazards of Farming discusses a series of related subjects covering varied risks in the workplace of farming. This book, one of a series, eminates from a group of specialists who demonstrate an excellent grasp of their subjects.

It has been said farming is America's most dangerous line of work, having eclipsed mining as the occupation having the highest death rate. The National Institute for Occupational Safety and Health and the office of the U.S. Surgeon General have given much impetus to the movement to control the problem of death and disease on the farm. Subjects in this book include:

Cancer among farmers
Effects of noise and vibration
Effects of heat and cold
Chemical hazards
Respiratory risks
Occupational infections
Reptile and anthropod envenomations
Pesticide-related dermatoses
Mental health issues

Agriculture injuries
Health of migrant workers
Use of cooperative extension services in
health education
Prevention measures that can be accom-

plished in the agriculture setting

Many reference citations are provided to give

an excellent overview of the health hazards of farming.

The other book I wish to bring to the attention of our readers involves agriculture in a somewhat tangential manner. *Trashing the Planet*, by Dixy Lee Ray with Lou Guzzo, is most interesting to read; provocative also. Questions about environmental hazards have become a tug-of-war between politicians and responsible scientists. Much controversy has evolved about acid rain, nuclear waste, dioxin and depletion of the ozone. The authors emphasize how little of the truth the public knows about the environment. In many instances the public has been bombarded by unscientific data based on illogical as well as untrue conclusions by self-serving alarmists.

This a controversial book, but worth reading because of the illumination it presents of a lot of the propaganda disseminated to the public.

"Call me Doc"

The bright lights of the big city hold no attraction for these two rural lowa family physicians. The true rewards, they say, can be found in a small town medical practice.



A. Clinton
MacKinney, M.D.
Cresco, Iowa

AY DAWNS AND I FEEL particularly comfortable and happy. An hour ago, two proud parents and I welcomed a baby girl into the world. And what an enchanting world she will soon see—rural Iowa. My truck almost drives itself home, unfettered by traffic jams and traffic lights. The clean cold air braces me through the half open window. Sunrise rituals surround me; dog walks, farm chores . . . but I may not notice. After a newborn delivery, an enigmatic mix of joy and relief often clouds my perception.

An unlikely pastoral scene? Not at all. This mini-drama has played daily over the years starring countless "country doctors." Today, more than our name has changed. Many of us are board-certified family practitioners. Expanded training, complex medical technologies, third party payors, PPO's and PRO's make rural practice vastly different from the medicine of even 20 years ago. However, rural life smooths modern medi-

cine's jagged edges and mollifies the physician soul disquieted by today's medical climate.

Four thousand people, all directly or indirectly dependent on agriculture, call Cresco home. Rolling corn, soybean and grass fields peppered by woodland pockets fill the countryside. The traditional farm family supplies the social-moral foundation. We are somewhat insulated from Madison Avenue insincerity, hostile corporate takeovers and violent crime. We share a sense of community pride and responsibility.

Envy of the nation

Iowa calls itself a "State of Minds." Certainly, Iowa can take pride in its superior educational institutions, but the label goes further. The Iowa state of mind is an attitude, a value system and a way of life. Brainreserve, a trend-watching consulting firm, reports, "The uncluttered, unbridled lives of Midwesterners will become the envy of the nation by the next century."

Rural Iowans are friendly and neighborly. No insincere smiles or lukewarm handshakes here. Relaxed relationships make for lasting friendships. An ubiquitous sense of "community" creates belonging. Shared history and experience confer community membership. Trust, openness and concern flourish when all share this sense of community.

Hard-work and independence come naturally to the people of rural Iowa. Farming 'Therefore, my medical care is more accurate, efficient and personally satisfying. Rural lowa allows me to enjoy the "art" of medicine.'

traditionally entails long hours of physically demanding work. Even children are indoctrinated early, often by necessity. Iowans have a "can-do" attitude. They are wizards at fixing things, from big budget tractors to fences.

Rural Iowans are religious, patriotic, respectful and law-abiding. Small town safety from violent crime is legendary. Unlocked doors and keys found in the ignition occur commonly. A walk in downtown Cresco is just as safe at midnight as at noon. Ingrained mores of honor and personal integrity police community members indirectly. These qualities explain the great demand for Midwestern nannies. Young Iowans bring to their employment honesty, hard work and a sense of right and wrong.

A connection with nature

If the heart of Iowa is its people, then the land is the playground so many across the nation seek. Eye-stinging smog, all-night sirens and concrete wastelands are but mass media images in the heartland. Instead, the sweet fragrance of fresh-cut hay, the soothing evening owl call and the new dawn's refreshing promise renew our capacity for awe and appreciation.

The rural experience fills the instinctive need for a "natural" connection. Rural Iowa provides the outdoors just outside the back door. Children grow up appreciating the value of natural resource conservatorship. They learn quickly that the land provides not just recreation, but livelihood and home.

Rural America may be trendy for the 1990s, but what about rural medicine and rural doctors? To a significant degree, our patients define rural medicine. They are generally older, more trusting and less litigious. Patients are not just diagnoses or CPT codes. They are community members and frequently close friends. Rarely do I see a patient I do not know. It is easy to remain familiar with the past history, social history,

family history, and even current medications and allergies of "regular" patients. Therefore, my medical care is more accurate, efficient and personally satisfying. Rural Iowa allows me to enjoy the "art" of medicine.

Truly, the primary care physician epitomizes rural health care. Rural doctors are not simply a small cog on a big wheel, they are the wheel. This pivotal position calls for creativity, enthusiasm and leadership. The opportunities and rewards are vast.

Communities seek physicians

In 1991, 151 Iowa communities sought 258 primary care physicians and 26% of Iowa's practicing primary care physicians were over the age of 55 according to the U. of I. Office of Community-Based Programs. The demand for rural primary care physicians will mushroom through the remainder of the decade. The successful future of Iowa's rural community depends upon high quality and comprehensive health care delivered by the primary care physician. In turn, rural Iowa offers much to physicians—friendly people, an unspoiled landscape, a safe environment for children and an opportunity for professional and personal fulfillment.



David Archer, M.D.Gowrie, Iowa

HAVE BEEN A FAMILY practitioner in rural Iowa since 1986. I chose to practice in an underserved area in exchange for medical school expenses and because they need me here. I have chosen to stay because I love the work and lifestyle.

I remember reading articles about professionals in a variety of fields who left highpaying jobs for "more rewarding" jobs and the notion haunted me. I left graduate school and turned away from academic medicine

(Continued next page)

because of those articles and I've never looked back. I deeply enjoy my practice.

Every day brings a variety of cases that cross all boundaries of body system and pathology. I see babies, athletes, trauma, hypertensives, diabetics, farmers, truckers, housewives, my banker, my kids' teachers, my minister's wife and the principal's fatherin-law. I still do housecalls and I go to nursing homes and a chemical dependency rehab center. I get up in the middle of the night to deliver babies and have provided service for barter.

No threat of litigation

The threat of litigation is almost nonexistent (I delivered an attorney of an eight-pounder). Patients keep their appointments. Folks around here call me "Doc" and ask for medical advice in the check out line at Jeff's Foodland.

However, there seems to be a sentiment among some that a specialist, specifically a distant specialist, is required to diagnose and treat a serious illness. These tend to be the same people who comment after an office or ER visit, "You're a pretty good doctor! What're you doing here?" Unfortunately, this sentiment seem to be pervading the halls of some medical schools as well.

Family practice is the lowest paid specialty and—like other primary care specialties—tends to be a labor of love. Students learn quickly that the easiest way to gain the favor of a preceptor is to express an interest in their specialty; and universities, being urban, provide no rural role models.

A professor in my senior year told me he'd put in a good word for me at Barnes in St. Louis. I chose family practice despite his contention that I'd see nothing but sore throats and runny noses. I believe that behind every runny nose there is a person.

Many rewards

I admit the lifestyle is not for everybody. The 'town doc' becomes involved in everyone's lives on a very personal level. We do more with less and to a great extent rely on the history and physical—definitely not a lost art in primary care. Being involved in your patients' lives is deeply rewarding and provides an antidote to the growing trend for us to become entrepreneurs and interchangeable "providers."

At a time when medical care costs are out of control, affordable access is not so much a problem of a doctor shortage but of maldistribution. State governments including Iowa are considering legislation to pressure medical schools to turn out a quota of pri-

'The threat of litigation is almost nonexistent. Folks around here call me "Doc" and ask for medical advice in the check out line at Jeff's Foodland.'

mary care doctors. I believe a better solution would be equitable reimbursement between urban and rural so new graduates with heavy loan burden can afford to go to underserved areas. Finally, the profession must consider rural primary care a specialty in its own right. We who choose this path fulfill a need where no other specialty could survive and with rewards that cannot be bought with money.



Hospital-specific data to be released to public

The first report from the lowa Health Data Commission on severity/outcome in 26 lowa hospitals will be released to the public. At a recent Des Moines conference, experts discussed possible public reaction and how hospitals and physicians can prepare.

A NOUTPOURING OF CONSUMER activism is not anticipated when data on cost, severity and outcome collected from Iowa hospitals are released to the public for the first time this month, experts at a recent conference told 147 representatives of Iowa's health care industry.

The conference, cosponsored by the Iowa Medical Society and other groups, was organized to help hospitals and physicians prepare for the first release of MedisGroups data by the Iowa Health Data Commission (IHDC). In 1989, the IHDC mandated that 26 of Iowa's large hospitals use the MedisGroups data collection program.

Data on 66 DRGs

The system has been in place for 18 months and carries a first-year price tag of \$3.5 million.

"We're about to witness the value of that investment," commented Don Dunn, president of the Iowa Hospital Association.

The IHDC report to be released this month will include hospital-specific data on 66 common DRGs, individual hospital sum-

maries, outlier reports and Iowa hospital profiles. Participating hospitals have been given the opportunity to review the data and comment, said Charles Palmer, IHDC chairman.

The report will include data on hospital charges, but that data have been adjusted for various factors such as wages, said Stephen Vanourny, M.D., chairman of the IHDC's Severity/Outcome Task Force. Dr. Vanourny

'Extremely small numbers could be misleading to the public.'

also said data which did not include at least 30 cases will be released only in summary reports since "extremely small numbers could be misleading" to the public.

However, Dr. Vanourny admitted there is disagreement among task force members regarding what should be done with DRG data reports containing "too many zeroes and ones."

(Continued next page)

Alan Brewster, M.D. of Westborough, Massachusetts, one of the major developers of the data collection system being used here, said the data should be used internally by hospitals "to meet the requirements of the customers and improve the consistency of their clinical processes."

Several of the conference speakers were from Pennsylvania, which has had the Medis-

'There's no use attacking the data. It's the best we have to date.'

Groups system for almost six years. When the first public report was released in that state, almost all attention focused on one newspaper story entitled "Heart Surgeons Rated." The story, accompanied by pictures of several prominent surgeons, contained controversial data regarding surgical outcomes and inconsistent charges.

Prepare for media questions

Although they feel a firestorm of public reaction to the data's release is unlikely, the Pennsylvania experts advised Iowa hospitals and physicians to be prepared to deal with media questions. David Jones, M.D., physician consultant to the Hospital Association of Pennsylvania, said media coverage there fell into two categories: small town newspapers were "protective" of their local hospitals and media in larger markets were "tough, obviously feel they were acting on behalf of the public."

Steven Caywood, CEO of West Penn Hospital in Pittsburgh, said at first he opposed "having MedisGroups shoved down our throats" but that he has come full circle because of the big business representatives on his hospital board who were looking for "a way to choose the best health care."

"There's no use attacking the data — it's the best we have to date," Caywood said. "Some of our hospitals have acted to improve their process because of the data."

Caywood said the next step in Pennsylvania will be collecting MedisGroups data for hospitals with fewer than 100 beds. He believes release of physician-specific data is inevitable in the future.

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References:

- A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
- Goodman, Gilman The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
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AMA trustee has fast feet



(At left) AMA Trustee Nancy Dickey, M.D. (center) with Better Homes and Gardens editor Paul Krantz (left) and assistant editor John Thomas; (above left) Dr. Dickey was a guest on Jan Michaelson's WHO-radio program; (above) Dr. Dickey's killer schedule is arranged by Patricia Clark (standing), media coordinator for the AMA.

SHE'S ELOQUENT, she's personable, she's knowledgeable, she has a great sense of humor and, boy, is she fast on her feet.

AMA Trustee Dr. Nancy Dickey found time to keep a mind-boggling number of engagements during a two-day Des Moines visit last month but said the packed schedule was fairly light compared with other trips.

This Texas physician makes at least 100 trips a year for the AMA and maintains a family practice . . . a tough assignment, but the energetic Dr. Dickey seems to thrive on it.

Accompanied by Patricia Clark, AMA media coordinator, Dr. Dickey met with editors at *Better Homes and Gardens* and the *Des Moines Register*, did interviews for KCCI-TV and WHO-TV and traded quips with WHO-radio morning talk show host Jan Michaelson. Michaelson, Dr. Dickey and callers discussed health care access, the Canadian sys-

tem and other issues. Dr. Dickey was very impressed with the callers and their questions.

"These people aren't shooting from the hip—they've thought about this stuff," she commented. "This spoils me for other cities."

Dr. Dickey's schedule also included dinner with the IMS Board of Trustees and representatives of the Iowa Academy of Family Physicians and an IMS Executive Council meeting. Her last engagement was a discussion of ethical issues at a joint dinner of the IMS and the Iowa State Bar Association.

Iowa Supreme Court Justice Linda Neuman said Dr. Dickey's remarks challenged her to "think critically" about her role as an advisor on tough ethical issues.

"Dr. Dickey's eloquence, candor and insight remind us we owe a duty to those we serve to elevate these issues for public scrutiny."

Family physician supply: a perspective

For the past decade, statistics on the supply of family physicians in lowa—particularly in rural areas—have been discouraging. However, experts at the University of lowa say there are signs of progress.

Editor's note: This article was compiled from information supplied by the Office of Community-Based Programs, University of Iowa College of Medicine.

The NEED and DEMand for family physicians in Iowa has been at a high level since the 1980s. However, there are signs of progress and promise when this subject is viewed in a broad context.

There are benchmarks suggesting the supply of family physicians in Iowa is a serious matter. Currently, 172 communities are attempting to recruit family physicians. According to an analysis done by the Office of Community-Based Programs, at least 85% of these practice opportunities are viable.

The percentage of family doctors declined from 38% to 29% of all Iowa physicians during the period from 1977 to 1990. The number of active Iowa family physicians declined by 5% during that same period, despite the record number of family physicians trained in Iowa's statewide training program. (This percentage does not take into account family practice graduates doing primary care in emergency rooms.)

These trends become even more meaningful when you consider the family physi-

cians are the principal source of primary medical care in Iowa.

But, there is a broader viewpoint that puts physician supply—particularly family physician supply—in a more thoughtful perspective.

Keeping pace with losses

The Statewide Family Practice Training Program—established by the Iowa Legislature and administered by the U. of I. College of Medicine—has enabled Iowa to nearly keep pace with the high rates of retirement and relocation among Iowa's family physicians during the 1980s. The program is Iowa's major source of family physicians, with enrollment as of January, 1992 at 151 (108 medical doctors and 43 osteopathic doctors).

In fact, University of Iowa medical graduates are entering careers in family practice at a rate approximately twice the national average for all medical graduates. (The national average in 1991 was 9%.)

Much of the family physician loss occurred in the late 1980s. The cause of the net losses is not fully understood but is thought to have been associated with a complex combination of social, economic and professional phenomena that have had influence far beyond family medicine.

STATEWIDE FAMILY PRACTICE TRAINING PROGRAM



For example, Iowa's population declined by 137,000 in the 1980s, which—taken alone—would have eliminated the need for 67 primary care physicians. Also, the state's economy has been depressed, particularly in rural areas. Other developments having serious economic consequences for medical professionals in the 1980s were the liability climate and Medicare reimbursement inequities for rural physicians.

Thus, it is not surprising that many Iowa physicians—particularly those in solo practice—retired at an earlier age than was the norm for Iowa physicians. (Average retirement age for Iowa physicians declined by more than five years during the 1980s.) Others left their practice locations for salaried positions.

Hopeful signs

Despite all this, there are indications the situation could improve:

- The professional liability climate in Iowa has stabilized.
- ◆ Congress enacted sweeping Medicare payment reform which is currently being implemented. Though meaningful improvements won't be fully in place until 1996, these changes especially favor primary care physicians and rural physicians. These improvements are mitigated somewhat by provisions which limit first-year reimbursement to new physicians (as defined by Medicare) to 80% of amounts paid to established physicians.
- By August of 1990, the number of practicing family physicians who were past age 60 and subject to retirement in the near term had declined to 19% of the state's family physicians. Fifteen years ago, 30% of our

RESIDENT SUMMARY

IOWA FAMILY PRACTICE RESIDENCY PROGRAMS

1991-1992

	No. of Residents				Female/Male	
Program	R1	R2	R3	Total	F	М
Broadlawns	0	7	8	15	6	9
Cedar Rapids	7	8	8	23	8	15
Davenport	4	5	6	15	6	9
lowa Lutheran (DM)	6	6	5	17	8	Ğ
Mason City	5	7	3	15	4	11
Sioux City	7	7	5	19	5	14
Waterloo	5	7	4	16	6	10
University of lowa	5	8	7	20	8	12
Des Moines General	-	4	7	11	5	6
	39	59	53	151	56 (37%)	(639

family physicians were past age 60. Our physician population is rapidly becoming younger; after 1995, retirement will not be a significant factor affecting supply.

• Our rate of family physician losses is the same for both rural and urban towns in Iowa. The difference is urban areas are able to replace losses faster.

• A regional pattern of over 200 medical branch offices has emerged statewide as a new source of medical services for towns with populations under 2,500.

 Regional networks of primary care physicians are being organized and sponsored by Iowa hospitals and a few multispecialty group practice organizations. The sponsors help attract family physicians to rural towns.

The annual net losses of family physicians have begun to decline. The current professional environment in our state shows clear signs of improvement. Therefore we can expect some improvement in the state's ability to attract and retain physicians.

Competition for family physicians across Iowa will remain keen well into the 1990s. However, beyond the alarming statistics from the 1980s, there are signs of progress and hope. Iowa, compared to many states, is in a favorable position with its statewide family physician training program, the ready availability of regional resources and an improving professional environment. The outlook is promising.



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Robert J. Fitzgibbons, Jr., M.D. Associate Professor of Surgery

Chief of Division of Surgery Creighton University School of Medicine Ralph Ger, M.D.

Professor, Surgery and Anatomy Chairman, Department of Surgery Winthrop-University Hospital

Docteur Namir Katkhouda Chief of Surgical Endoscopy

Hospital St.-Roch Nice. France

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Questions and Answers



Merlin Plagge

Health care access is vital issue to Farm Bureau

The Iowa Farm Bureau, dedicated to improving the quality of life in rural Iowa, is very concerned about access to quality health care. The author, president of the Iowa Farm Bureau Federation, says more incentives must be developed to entice health care professionals into rural Iowa.

What is the Iowa Farm Bureau Federation and what is its basic mission?

The Iowa Farm Bureau Federation is a federation of 100 county Farm Bureaus with a membership of more than 154,000 families. The Iowa Farm Bureau Federation helps coordinate activities for those county Farm Bureaus. All county Farm Bureaus are organized at the local level with a board of directors that meets monthly and carries out programs within that county.

The mission of Iowa Farm Bureau is improving net farm income and the quality of life for Iowans. Farm Bureau is involved in education, legislation and economic services to fulfill this mission.

Iowa Farm Bureau continues to be the voice of agriculture in Iowa serving the farmers of Iowa. Although our major thrust continues

to be in the legislative area, a major effort by the Iowa Farm Bureau Federation is to provide services for its members.

As we look at improving the quality of life in rural Iowa, health care is a primary issue. Iowa Farm Bureau has dedicated a great deal of time and effort to this issue in recent years due to the increasing costs and the concern over the lack of access to health care in the coming years.

The Iowa Farm Bureau has taken a keen interest in rural health care issues. What do you think is the major problem facing rural Iowans with respect to health care?

Many complex problems face rural Iowa's health care delivery system. I believe, however, that the major problem is one of access to high

(Continued next page)

quality and affordable health care. Clearly, this is not a problem that is easily solved.

A key component to solving it, however, is increasing the supply and distribution of health professionals and health care services to rural communities. Another vital component is reorienting our thinking about what services are needed and what is the best way to deliver these services in rural Iowa. Lastly, the trend of underpayment by government programs to rural providers needs to be reversed.

In order to more effectively deal with the problems of access, cost, quality and physician burnout, new models for the delivery of primary health care services are needed. By establishing new provider networks—or "organized delivery systems" for health care services—solutions to this serious need of primary health care professionals in rural Iowa can be addressed.

Our medical and allied health professional schools need to focus more on training primary health care professionals such as family practitioners, internists and pediatricians—and less on the high-tech specialties and sub-specialties. The phenomenal and unprecedented growth these specialties have enjoyed in the last 20 years has been directly at the expense of primary care. This has hit rural communities the hardest.

Incentives need to continue being developed that will encourage primary care graduates of Iowa's medical schools to remain in the state—preferably in rural practice. To their credit, Iowa's schools which train physicians continue to make progress toward this end.

How is the Iowa Farm Bureau addressing concerns about cost, quality and access to care?

The Iowa Farm Bureau has been aggressively addressing the issues facing rural Iowa. Internally, Farm Bureau staff has been dedicated to the task of assuring access to high quality and affordable health care through our member health insurance plan. Various high-level task forces have been involved in making our member health plan more responsive to our members' changing needs and expectations.

Over the last few years, health care in rural Iowa has been a prominent and increasing focus of Farm Bureau statewide and county level meetings. Farm Bureau leadership and staff at both these levels have redoubled their commitment to find meaningful and workable solutions to our state's rural health care needs.

Farm Bureau leadership and staff have been active in a variety of activities that have confronted the problems inherent in Iowa's rural health care delivery system. Among other things, I currently serve on the Iowa Leadership Consortium on Health Care, which has just recently completed its discussion draft, as well as on the board of the Health Policy Corporation of Iowa. Daryl Siebens, IFBF vicepresident, has served on the Iowa Department of Health's Rural Health Advisory Committee, which deals with a variety of issues affecting rural Iowa's health care delivery system.

Farm Bureau is developing a multi-faceted rural medical education scholarship loan program. This program will not only provide scholarships and loans to medical students and other prospective primary health professionals willing to commit to a rural (primary care) practice, but it will also fund development of programs to foster interest in the health professions at the high school level through various promotional activities, such as videos.

Is the Iowa Farm Bureau involved in the recruitment of physicians to rural Iowa?

The Iowa Farm Bureau is not directly involved in the recruitment of physicians to rural Iowa. However, we are developing our rural medical education scholarship/loan program to create incentives for medical and other health professional students to locate in rural Iowa. Farm Bureau also supports a state appropriation for scholarships for physicians who will practice in rural Iowa.

County Farm Bureau leaders are also active in their local communities, through such activities as serving on local chambers of commerce, school boards, county boards of supervisors, local hospital boards and the like. In these capacities, local Farm Bureau leadership can and does make a difference at the community level.

I believe the most effective role for the Farm Bureau is to serve as a facilitator. These communities need to continue to work directly with physician and other health professional prospects, in order to assure the unique needs are addressed and met. I feel that the most meaningful role for the Iowa Farm Bureau is to remain actively involved in the ongoing statewide discussions about appropriate rural health care policy and identifying new and effective models that will maximize the value of health care in rural Iowa.



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Letters to the Editor

Liked January article, but wants more fashion advice

To the Editors:

I enjoyed the article, "A physician's day in court: 2 perspectives," by Jerry Jochims, M.D. and H. Richard Smith, J.D. in the January issue. Medical-legal issues are certainly complex as well as prominent and the medical profession can benefit by becoming more informed regarding such issues.

I do have one question, regarding Dr. Jochims' suggestion that a medical expert wear a plain suit and a subtle tie "which suggests confidence without distracting from your facial features." Could he please suggest some specific tie colors and patterns that might accomplish this objective? Such a tie sounds like a useful fashion accessory. I think I need to go tie shopping.—Michelle Ochs, M2, U. of I. College of Medicine, Iowa City, Iowa.

And, on the light side . . .

To the Editors:

I appreciate the response I have had regarding the article I authored for the recent medical/legal issue of *IOWA MEDICINE*.

Two of what our old guard might consider our more feminist readers have brought my attention to the comments regarding the appropriate attire to be worn by the expert witness. I would only suggest that it is perhaps more possible that the female physician expert witness be able to find a plain suit with a subtle tie than it might be for this author to find the most appropriate dress.

I am flattered that at least two of our readers perused this article in such depth. I hope they will find my dress equally flattering.—*Jerry Jochims, M.D., Burlington.*

Critical of AMA's 'self-serving' voice

Dear Editor:

However you slice it, the AMA position on health care reform and the usual posturing of the professional medical societies can only be interpreted as yet another self-serving voice struggling to protect a turf and a pocketbook. As physicians we are trained to act in the aid of strangers who are suffering, not act on our own behalf with strangers who are suffering. In the same model we should be behaving in the best interest of our country. In my view the health of our country will best be served by protecting the growing parts. We should have prenatal and early child care and development a major pillar of any health care policy proposed by physicians. Healthy babies, kids, and families produce healthy, productive adults and will launch our country on into the 22nd century. Frankly, all other issues are secondary. The AMA and the Iowa Medical Society should lead. Leaders typically have a vision of the future beyond the next two or three years.-Selden Spencer, M.D., Ames.

Disabled children eligible for free dental care

Free dental services are available to persons with low incomes who are disabled through a program sponsored by the Department of Pediatric Dentistry, University of Iowa, in conjunction with the Iowa Department of Public Health.

Since beginning the program in 1983, over 1000 children in 92 counties with varied disabilities including cerebral palsy, hemophilia, learning disorders, mental disabilities, hearing and vision impairments and cancer have been served.

In order to qualify for the program, three criteria must be met: (1) client must be 21 years of age or under, (2) income of client's family should be under 150% of the federal poverty guidelines, (3) client must be developmentally disabled.

Qualifying patients will be eligible to receive limited preventive and restorative treatment. Orthodontic treatment will not be available due to restrictive funding. Patients are treated in Iowa City at the University Hospital School Dental Clinic or in one of 10 offices located throughout the state.

Further information may be obtained and patient referrals may be made by calling or writing to Lynette Lancial, Project Coordinator, University Hospital School, Dentistry Department, University of Iowa, Iowa City, Iowa 52242 or phone 319/356-1517.

A cure for nervousness

During a recent Des Moines conference sponsored by the Iowa Hospital Association, Dr. Alan Brewster of Westborough, Massachusetts shared a little known cure which he dis-

covered during his residency.

Dr. Brewster was the physician on call at the hospital late one night. He was called down to the emergency room to treat a young bartender who had just gotten off work. The young man claimed to be "nervous" and held out his trembling hands as

Just as Dr. Brewster was deciding how to deal with this vague symptom, the young man said, "I just came here so you can weave my fingers like the other doctor did." When Dr. Brewster professed ignorance regarding this treatment, the young man described the technique, which involved threading gauze over and under the fingers of each hand.

After extracting a promise from the young man not to tell anyone who treated him, Dr. Brewster proceeded with the gauze finger-weaving cure. Fingers woven together and hands steady, the young man went away satisfied.

LETTERS TO THE EDITOR

If you have a comment regarding something you've read in IOWA MEDICINE or an observation on conditions affecting the practice of medicine in Iowa, don't keep it to yourself. Share your thoughts in a letter to the editor. We'd like to hear from you.



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Lead intoxication in lowa children

In lowa, there are over 600,000 residential units built before 1950 which are high risk environments for children due to deteriorating lead paint. However, there are relatively few lead screening programs in lowa, and only selected children in lowa have been screened.

Douglas Weismann, M.D.

Iowa City, Iowa

A LTHOUGH LEAD INTOXICATION HAS been recognized as a problem in children for several decades, recent evidence heightens the sense of urgency regarding this problem. The Agency for Toxic Substances and Disease Registry (ATSDR) of the U.S. Public Health Service reported in July 1988 that an estimated 17% of pre-school children (roughly 3-4 million children) may be at risk for the adverse consequences of lead exposure. Due to increasing scientific scrutiny, the blood lead level at which adverse effects are recognized to occur in children continues to be lowered. It is becoming obvious there is no "safe" level of lead exposure.

Lead accumulates in body

Lead is pervasive in our environment. It is found as a contaminant in dust, soil, air, water

Dr. Weismann is associate professor of pediatrics and co-medical director of the University of Iowa Poison Control Center.

and food.² The largest source of exposure is lead released from paint on dilapidated and deteriorating pre-1970 (especially pre-1950) housing. The deteriorating paint falls to the ground or other surfaces as chips or lead-containing dust which young children ingest. Lead is absorbed well through the GI tract but eliminated from the body very slowly.⁵ Thus, lead can cause acute symptoms and can slowly accumulate in the body over time and produce toxic effects.

Children are more susceptible to lead exposures because of their increased hand-tomouth activity as well as increased efficiency of absorption of lead from the GI tract and the effect of lead on immature organ systems.⁵ Absorption of lead from the GI tract is further enhanced by nutritional deficiencies of iron, calcium and zinc. Unborn children may also be exposed prenatally by transplacental transfer of lead released from storage areas in their mother during pregnancy.⁵

Symptoms of lead intoxication (abdominal colic, nephropathy, and encephalopathy with coma or even death) occur at high blood lead levels and are now rare. More common, and

THE IOWA MEDICAL FOUNDATION HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION AWARD FOR MARCH 1992

of increasing concern, are the subtle toxicities which occur at much lower blood lead levels. These toxicities include developmental dysfunction, growth impairment, hearing loss and decreases in IQ scores.⁴ As a result of these new data, the Center for Disease Control (CDC) will lower the threshold blood lead level from the 25µg/dl level established in 1985 to 10 µg/dl.

To prevent adverse consequences of lead exposure, the CDC recommends an active screening and prevention program. This will require virtually universal screening of children. There are only limited government sponsored lead screening programs in lowa, placing a burden on primary care practitioners to perform appropriate testing. The previous screening test-of-choice, the erythrocyte protoporphyrin test, is insensitive at low levels of blood lead. Consequently, the current screening method-of-choice is direct measurement of lead in blood.

Low Risk

Start blood lead (BPb) screening age 12 mo.

BPb >20 µg/dl

BPb >10-19 µg/dl

BPb <10 µg/dl

Rescreen annually or when change in risk status

Environmental & Nutritional Counseling

High Risk

Start blood lead (BPb) screening age 6 mo.

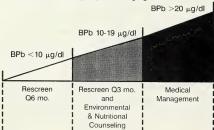


Figure 1. Flow chart for blood lead (BPb) screening of low and high risk children for lead intoxication up to 36 months of age. High risk children are defined in Table 1.

Who is at risk?

Screening, as recommended by the CDC, should include targeting of high risk children.⁷ Children at risk are: children who live in or frequently visit deteriorated housing built before 1970; children who live in pre-1970 housing which is being renovated; siblings or playmates of children with lead poisoning; children whose parents have lead-related occupations or hobbies; children who live near lead smelters, battery recycling plants, etc; and children with growth, hearing, neurologic or developmental disturbances.

A flow chart for lead screening is depicted in Figure 1. Children who have been screened every 3 months with consecutive blood lead levels <15µg/dl should subsequently be screened every 6 months. After 36 months of age, high risk children or those with recent blood lead levels >10µg/dl should be screened annually to age 6 years. Others need no further screening unless risk assessment changes.

Patients with blood lead level >20µg/dl should be tested with an erythrocyte protoporphyrin (EP) test and a CaEDTA mobilization test (Table 1) to determine if excess body burden of lead is present. If the patient has a positive CaEDTA mobilization test or a blood lead level >40µg/dl, chelation therapy is indicated (Tables 2 and 3). A new orally active chelating agent (succimer) has been approved by the Federal Drug Administration (FDA) for treatment of children with blood lead levels greater than 45µg/dl. Succimer (Chemet, McNeil Laboratories) has been shown in clinical studies to be as effective as CaEDTA in treatment of lead intoxication. Succimer has the advantage of being orally active and it does not deplete body stores of iron, calcium and zinc.8 Unfortunately, it has not yet been adequately studied in treatment of children with blood lead levels less than 45ug/dl.

High risk patients for lead intoxication have traditionally been identified as inner city, minority youth. However, there is no socioeconomic group, geographic area or racial group which is spared this problem. According to census data from 1980, Iowa has approximately 600,000 residential units built prior to 1950; many are in a deteriorated condition. Lead contamination from deteriorating lead based paint make these units high risk environments for

children.

(Continued on page 122)

TABLE 1 DIAGNOSTIC CaNa.EDTA PROVOCATION (MOBILIZATION) TEST

-		
CaNa₂EDTA	500 mg/m² (max. dose 1 gram)	Give as IV infusion over 1 hour (0.5% in D5W). Collect urine for 6 hours. Determine lead excretion ratio:
		(CaNa ₂ EDTA given in mg)
	If ratio ≥ 0.6, give CaNa₂EDTA 1000 mg/m²/d or	Treat for 5 days IV.
	succimer 1050 mg/m²/d	$350~\text{mg/m}^2~\text{q8h}$ orally for 5 days, then $350~\text{mg/m}^2~\text{q12h}$ orally for additional 2 weeks.
	If ratio ≤ 0.6, educational and nutritional interventions	Repeat blood Pb and CaNa ₂ EDTA provocation test periodically.

CaNa₂EDTA—calcium disodium ethylenediaminetetraacetic acid (calcium disodium edetate, Versenate) succimer—2,3 dimercaptosuccinic acid (DMSA, Chemet)

Adapted from Piomelli S, et al: Management of childhood lead poisoning. J Pediatr 1984;105:527, with permission.

TABLE 2
INDICATIONS AND METHOD OF CHELATION THERAPY FOR SYMPTOMATIC CHILDREN

Clinical Presentation	Treatment	Comments
Acute encephalopathy	BAL 450 mg/m²/d CaNa₂EDTA 1500 mg/m²/d	Start with BAL, 75 mg/m² IM q4h After 4 h, start continuous infusion of CaNa ₂ EDTA 1500 mg/m²/d for
		5 days. Interrupt therapy for 2 days. Treat for 5 additional days with combined therapy if blood lead remains high.
Other symptoms	BAL 300 mg/m ² /d	Start with BAL, 50 mg/m ² IM q4h
	CaNa₂EDTA 1000 mg/m²/d	After 4 h, start CaNa ₂ EDTA, 1000 mg/m ² /d, preferably by continuous infusion or in divided doses IV (through heparin lock). Treat for 5 days. BAL may be discontinued after 3 d if blood lead <50 μg/dl. Interrupt therapy for 2 days. Treat for 5 additional days if blood lead remains high.

BAL-2,3-dimercaptopropanol (dimercaprol, British anti-lewisite)

CaNa₂EDTA—Calcium disodium ethylenediaminetetraacetic acid (calcium disodium edetate, Versenate)

Adapted from Piomelli S, et al: Management of childhood lead poisoning. J Pediatr 1984;105:527, with permission.

TABLE 3
INDICATIONS AND METHOD OF CHELATION THERAPY FOR ASYMPTOMATIC CHILDREN

Clinical Presentation	Treatment	Comments
Blood lead > 70 µg/dl	BAL 300 mg/m²/d	Start with BAL, 50 mg/m² IM q4h
	CaNa₂EDTA 1000 mg/m²/d	After 4 h, start CaNa, EDTA 1000 mg/m²/d preferably by continuous infusion, or in divided doses IV (through heparin lock). Treat with CaNa, EDTA for 5 d. BAL may be discontinued after 3 days if blood lead < 50µg/dl.
Blood lead 45-69 μg/dl	CaNa₂EDTA 1000 mg/m²/d	Treat for 5 days, preferably by continuous infusion, or in divided doses IV (through heparin lock). Alternatively, if lead exposure is controlled, CaNa ₂ EDTA may be given as a single daily outpatient dose IM or IV.
	succimer 1050 mg/m²/d	Start dosage at 350 mg/m ² (10 mg/kg) q8h for 5 days, then 350 mg/m ² q12h for an additional 2 weeks.
Blood lead 20-44 μg/dl	Perform CaNa ₂ EDTA mobilization test	q. z.v. o. a.v. additona. z. v. ceta.
Blood lead 15-19 µg/dl	Educational and nutritional interventions	
Blood lead 10-14 µg/dl	Community prevention activities	

BAL-2,3-dimercaptopropanol (dimercaprol, British anti-lewisite)

CaNa₂EDTA—Calcium disodium ethylenediaminetetraacetic acid (calcium disodium edetate, Versenate)

succimer-2,3 dimercaptosuccinic acid (DMSA, Chemet)

Adapted from Piomelli S, et al: Management of childhood lead poisoning. J Pediatr 1984;105:527, with permission.

In 1985, the Iowa Department of Public Health (IDPH) undertook a survey of Iowa children to detect evidence of environment lead hazards. About 2,000 two-vear-olds enrolled in the Women-Infant-Children (WIC) program were tested. Twenty eight children (1.4%) had elevated blood lead levels (>25µg/ dl). These children were identified in Aurora, Clinton, Council Bluffs, Des Moines, Independence, Keokuk, Muscatine, Oskaloosa, Ottumwa, Sioux City, Spencer and Waterloo.

Community Screening Projects

In 1989, the state legislature allocated funds to the IDPH to establish community based screening projects. Council Bluffs, Des Moines and Waterloo were selected as project sites. These projects have been continued through 1991. Last year in the state funded projects, 3,998 children were screened and 23 children (0.6%) were identified with elevated blood lead levels (>25µg/dl). It is important to note these screening tests were performed at fixed site locations, thus limiting accessibility to these services of many of the region's children.

Local health departments in Davenport and Cedar Rapids also provide childhood lead screening, but only on demand. In 1990, 1,500 children in Davenport were screened with 8 children (0.5%) noted to have blood lead levels greater than 25µg/dl. In fiscal year 1990 395 children were screened in Linn County (Cedar Rapids) with 3 children identified with blood

lead levels greater than 25µg/dl.

These methods of screening for blood lead are selective and insensitive. The Centers for Disease Control, the IDPH and others are concerned that many children in Iowa and elsewhere may suffer adverse effects from undetected lead exposure. Symptoms of lead poisoning may not become evident for many years, at which time they may be irreversible.9

In 1991 additional funds allocated by the Iowa Legislature has allowed expansion of the Waterloo program to include a door-to-door screening component. Neighborhoods that demonstrate a substantial environmental lead hazard were targeted. This method will identify many more children than the fixed-site testing. However, it is clear childhood lead poisoning occurs in all parts of Iowa. The CDC estimates new guidelines lowering the threshold blood lead level to 10µg/dl may increase the number of at-risk children by 33-50%, although some workers in the field estimate their case loads may be doubled or tripled.

The low prevalence of symptoms and widespread lead exposure of children suggests the need for virtual universal screening of children for lead intoxication. It is imperative that health care providers become engaged in a cooperative effort with state legislature and public health agencies to detect, treat and prevent childhood lead intoxication.

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Sauna thoughts vs. truth

Richard M. Caplan, M.D.

The UNIVERSITY GYMNASIUM, about a block from my office, has a sauna that attracts me when I feel the need of exercise. How else—short of thinking myself into a panic attack—can I push my pulse rate up to 100 while lying perfectly still? That sauna isn't private, however, which means I occasionally meet someone I've needed to talk to, or someone amiable to chat with. Mostly, the patrons are a stream of men of varying ages whom I don't know and to whom I listen while my sweat glands grow earnest about their mission.

Amidst the usual banter about how the Hawkeyes are doing or not doing, I hear assertions about matters on which almost any physician might offer a definitive judgment that encapsulates truth. At such moments I usually manage to maintain my silence. For example:

"I hear Gatorade is especially good for you in a long game." "Naw, they've found out you're better off with plain water."

"They say it's better if you cool off

slowly."

"Muscle tone does better if you push yourself until it hurts—just so you don't push yourself while it hurts."

"You know that old story about 'starve a cold'? I think it needs to be just the oppo-

"You need to finish with a cold shower—it closes the pores."

"I take a glass of wine with dinner. I read it improves longevity."

"Wha'd'ya think of this stuff about oat bran? I think it's an advertising gimmick."

Occasionally conversation scintillates past me regarding membrane receptor sites or carbon dioxide gradients, but most of the claims deal with the musculoskeletal system, skin or nutrition. At times I feel I could give not only an expert's answer but one that is correct: "A cold shower doesn't close the pores; besides, if they did close and stayed that way, it would make lots of trouble." Usually I'm unsure of what is so, and that leads me to ponder the role of education in determining and propagating what is considered true.

The medical information that reaches us from company representatives, colleagues, in throwaways and journal advertising and even in "scientific articles" bears an enormous resemblance to sauna chatter. Somewhere-everywhere, probably, throughout life-we need instruction and practice in confronting and judging ideas. When can we accept the dogma of our elders or betters and when should we challenge it? To what extent can we place confidence in the results of statistical tests? Should pre-meds take a required course in logic? Should biostatistics become the centerpiece of the curriculum? How can we recognize good judgment and clinical wisdom? What does it mean to know something?

I feel fortunate, in retrospect, that I was required as an undergraduate to take a course called "Propaganda Analysis" in the English department at Iowa State. I've also enjoyed the benefit of other teachers and colleagues who've conditioned me to be more critical, discerning and reflective. I deem that to be not only valuable but satisfying. It even

makes the sauna more fun.

Dr. Caplan is Coordinator, Program in Medical Humanities at the University of Iowa College of Medicine.

A seminar in biomedical ethics

Robert Weir, Ph.D.

Last March I used this space to describe a required course in biomedical ethics at the University of Iowa College of Medicine. The course had been taught for the first time to the 170 second-year medical students in the fall of 1990. My reason for describing the course in this column was to give readers information on how the UI College of Medicine is changing the medical curriculum to prepare students to meet new changes and challenges in the practice of medicine.

This time I want to provide information on some additional courses in biomedical ethics offered at the University of Iowa. John Boyle, an associate professor in the School of Religion, has for a number of years taught an introductory course on biomedical ethics to undergraduates. Three years ago I started offering a graduate seminar in the spring semester to meet some of the interests and needs of graduate students and health-care professionals who indicated they would like to take or audit such a course.

From that time to the present, the course has been available for graduate credit through the UI School of Religion. It has also been open to physicians, nurses and other health professionals who want to audit it on a serious basis. Several have done so, meaning that they have agreed to read five books during the semester (approximately 100 pages a week) and take part in the weekly discussion session. Students taking the course for graduate credit are also required to keep a semester-long ethics journal that is turned in for a grade.

I thought you might be interested in knowing the material we are reading and discussing in the seminar this semester. Some of you, perhaps, will be sufficiently interested that you will want to make time in your busy schedules to do some of the reading.

The first book to be read and discussed is Ruth Macklin's *Mortal Choices* (Pantheon, 1987). Macklin is a professor of bioethics at the Albert Einstein College of Medicine, a position she began about 12 years ago. This book, written for a general audience, is a description of the range of clinical cases she has provided consults on, discussed with physicians and medical students, and written about over the years.

The Silent World of Doctor and Patient (Free Press, 1984) is the second book in the seminar. The author is Jay Katz, a psychiatrist who has worked at the Yale University School of Law for most of his career. He provides an excellent, multifaceted analysis of the physician-patient relationship, with special attention to the problems of informed consent.

Daniel Callahan is a philosopher, director of the Hastings Center, occasional visiting speaker in Iowa and a prolific writer. We discuss his book *Setting Limits* (Simon and Schuster, 1987) third in the seminar. This book is a controversial proposal for an agebased program of rationing scarce medical resources for older adults.

The next book is Paul Menzel's *Strong Medicine* (Oxford, 1991), a book that provides a much more philosophical analysis of the costs (financial, political, ethical and personal) of rationing health care or refusing to ration health care. Menzel, a professor of philosophy at Pacific Lutheran University, is one of the best analysts of current ethical problems involving health economics.

The last book is one of mine. Abating Treatment with Critically Ill Patients (Oxford, 1989) provides an analysis of dozens of clinical and legal cases, along with proposals on how to handle many of the difficult problems that arise when life-sustaining treatment is withheld, decelerated or withdrawn from critically ill patients.

Dr. Weir is director of the program in biomedical ethics for the University of Iowa College of Medicine.

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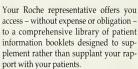


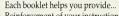
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The physician's role in coding

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Increasing Cash Flow

The first question deals with "time," or getting your payment in the shortest number of days. This requires that you turn in your charges in a timely manner. That doesn't mean weekly, semi-monthly or monthly. It means daily. I know you are busy, but it is important that you code each visit while it is still fresh in your mind.

Deciding which level of service you have provided and documented for your patient is critical. "Documented" is the key word. I'm sure you are already aware of the increased efforts of third party payors to require copies of your office visits, H&P's, consults, etc. The insurance reviewers are very willing to downcode your services because of incomplete documentation on your part. I cannot stress enough your role in providing detailed and accurate

Clean claims are a necessity. In order for a claim to be paid on the first handling, it must contain all the necessary information: (1) date of service, (2) place of service, (3) level of service — CPT code and (4) diagnosis—ICD-9

records on each patient.

If your claim is missing any of these items, it will be kicked out for review and a letter sent back to you to supply the necessary information. This will slow your claim down by days, if not weeks. The doctors in our office are our most important coders.

Improving reimbursement

The second question deals with getting better reimbursement from the carrier. Again, "documentation" is the operative word. A favorite quote in our office is "If it isn't documented—it didn't happen." In an insurance company's eyes, it doesn't matter how much time you spend with a patient or the complexity of the procedure; all it can pay on is what is documented in your patient record. The idea is simple, no documentation—no payment.

As indicated earlier, the fourth item of necessary information is the diagnosis code. Insurance companies are now scrutinizing diagnosis codes. Some insurance carriers have installed software to match the diagnosis code with the CPT code. Coding the diagnosis is becoming just as important as coding the level of service. Hospital reimbursement has been driven by diagnosis for years. This seems to be the direction in which physician reimbursement is heading.

ICD-10 is in the process of being rewritten. We understand there is discussion to greatly expand the number of codes now available. Insurance carriers are asking you to code the primary illness for which you are treating the patient as well as any symptoms that are present.

These concepts are simple and basic. Yet, without them you are looking at slow reimbursement or, worse yet, no reimbursement for the service you have provided.

This article was written by Renita Brand, business manager for Internal Medicine Faculty and Clinics in Des Moines and a member of the Iowa Medical Group Management Association.

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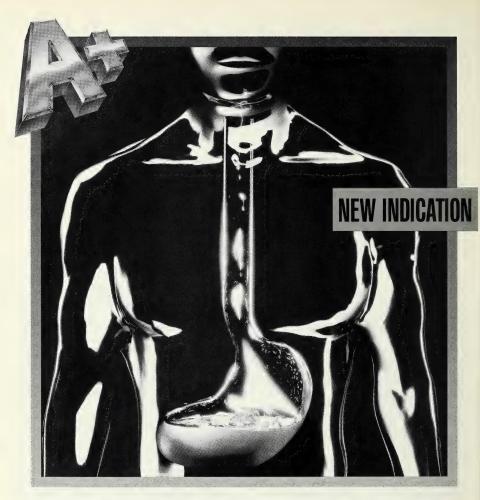
About Iowa Physicians

Items in this column are compiled from newspaper clippings from the Iowa Press Clipping Bureau. News from individual physicians, clinics and hospitals is welcomed and encouraged.

The following physicians were recently elected to the Iowa Academy of Family Physicians at the Academy's 43rd annual meeting in Des Moines: M.G. Parks, Centerville, president; Harold Ecklund, Des Moines, president-elect; Laine Dvorak, Humboldt, vice-president; Tom Evans, Des Moines, secretary/treasurer; David Carlyle, Algona, District 1 director; Steve Wolfe, Spencer, District 1 alternate director; John Carroll, Carroll, District 3 director; Richard Louvar, Cedar Rapids, District 4 alternate director; Charles Driscoll, Iowa City, delegate to the American Academy of Family Physicians; Larry Boeke, Des Moines, alternate delegate. Dr. Hadi Khan has left his practice with Britt Medical Clinic for a position in southern Illinois. Dr. Khan practiced at the Clinic for three years. Dr. Rufus Kruse has retired after 35 years of medical practice in Marshalltown. Dr. Kruse received the M.D. degree from the U. of I. College of Medicine and practiced in Conrad before locating in Marshalltown. Dr. James Justice recently joined Medical Associates of Cedar Rapids. Dr. Justice previously practiced in Dubuque. Dr. Matthew Petersen recently relocated from the Iowa Physicians Clinic in Des Moines to its affiliate office in Ankeny. Dr. George Hogenson has retired after 41 years of medical practice in Eagle Grove. Dr. Hogenson received the M.D. degree from the U. of I. College of Medicine. Dr. Charles Clark, professor of orthopedic surgery

at the U. of I. College of Medicine, was recently elected president of the Cervical Spine Research Society at the organization's annual meeting in Philadelphia, Pennsylvania. Dr. Peter Silberstein, of the Park Clinic in Mason City, recently received an outstanding volunteer award from the Cerro Gordo board of directors of the American Cancer Society, Iowa Division. Dr. Gerald Sunner, formerly of Cedar Rapids, has joined the staff of Merrill Pioneer Community Hospital and Pioneer Medical Center, Rock Rapids. Dr. Don Weideman, Vinton, has retired after 35 years of medical practice. Dr. Weideman received the M.D. degree from the U. of I. College of Medicine and served his internship at Broadlawns Medical Center, Des Moines. Dr. Mary Campbell, formerly of DeWitt Family Medical Center, has joined the Bettendorf Medical Center. Dr. Samuel Porter, Mason City, was recently appointed Midwest Surgical Association's Representative to the Board of Governors of the American College of Surgeons. Dr. Joseph Morris has joined Surgical Consultants, Sioux City. Dr. Morris received the M.D. degree from the U. of I. College of Medicine and completed a residency at the University of Nebraska Medical Center, Omaha, Nebraska. Dr. William Karkow, Manchester, and Dr. Stephen Piercy, Fort Dodge, recently became fellows of the American College of Surgeons. Dr. Luis Lebredo has joined

(Continued on page 133)



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nuzatione is similar to mal in normal subjects. Laboratory first F-lase-postive tests for urbilinogen with Multistix* may occur during therapy. Drug interactions—No interactions have been observed with theophylline, chloridizappoxide, forazepsim, lidocare, phenyfora, and warfarin. Aud does not inhibit the cytochrone F-25 or enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In platient given every high doess (3000 mg) of aspirin drug), increased surren salicyfalle levels were seen when nizotidine,

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between And and placebo in the incidence of any of these events (see passkape insert for compiler information). A variety of less common events were also reported; it was not possible to determine whether these were caused by mission provided in the property of the provided provided in the provided provided in the provided provided provided in some patients. In some cases, there was marked elevation (>>500 ULT) in related to mission occurred in some patients, in some cases, there was marked elevation (>>500 ULT) in the provided provided

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Surgical Consultants, Sioux City. Dr. Lebredo received the M.D. degree from the University of Illinois at Chicago Health Sciences Center, Chicago, Illinois and served his residency at Oregon Health Sciences University, Portland, Oregon. Dr. John Heffernan has joined Penn Avenue Internal Medicine, Des Moines. Dr. Heffernan has practiced in Des Moines for three years.

Deaths

Dr. Granville Richey, 85, formerly of Centerville, died December 21 in Midland, Texas. Dr. Richey received the M.D. degree from Indiana University School of Medicine, Indianapolis, Indiana and practiced in Centerville for many years, retiring in 1970. Dr. Richey was a life member of the Iowa Medical Society.

Dr. E. Thomas Sersland, 44, West Des Moines, died December 13. Dr. Sersland received the M.D. degree from Northwestern University Medical School, Chicago, Illinois and completed a residency at Mt. Sinai Medical Center, Miami Beach, Florida. Dr. Sersland had been a diagnostic radiologist with Mid-Iowa Radiology in Boone for five years. Prior to 1987 he practiced in Des Moines.

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Dissecting a problem

The first step toward solving a problem is dissecting that problem and analyzing its components.

That was the idea behind the National conference on Rural Health sponsored by the American Medical Association last September. At the conference, interdisciplinary discussion groups representing physicians, health care administrators, lawmakers, human resource experts and governmental agencies talked about what can be done to make rural medical practice more attractive and thus ease the access problems in states such as Iowa.

During three days of discussions, the group reached a consensus that "beginning a solo rural practice can be hazardous to one's

health" for several key reasons:

Constantly changing rules and regulations: "The current regulatory environment makes it difficult or impossible for a single physician or small group of physicians to establish a successful practice," said the report on the group discussions at the AMA's conference.

Lifestyle issues: When physicians choose a practice location, they look at family needs such as the quality of the school system, social environment and how many hours they will have to work (or be on call) each week.

Payment issues: The conference attendees cited Medicare payment inequities and the Medicare "hassle factor" as major factors hindering recruiting to rural areas. Attendees also expressed grave concern regarding the current payment limitations on new physicians.

Spouse issues: Increasingly, physician spouses are also professionals developing their own career track who are interested in the

number of opportunities available.

Education: It was the perception of many conference participants that the American medical education system is "failing to meet the needs of rural America." The committee cited the need for "greater flexibility in the area of family practice," more primary care role models for medical students and more emphasis on primary care in postgraduate training.

Student population: Students who come from small communities, the report said, tend to return to smaller communities once they have completed their medical education. In recent years, medical schools have seen a decline in students from rural areas. Attendees at the AMA's rural health conference called this an "ominous pattern with significant implications for the future."

Some suggestions very specific

The discussion also turned to solutions. Some of the suggestions for change were obvious; others, like these, were very specific:

 Expand the definition of primary care in rural areas to include general surgery and

orthopedics.

Make reimbursement to rural areas

greater than urban areas.

 Work with state legislatures to include programs such as the University of Minnesota's Rural Physician Associate Program in premed curriculum and thus encourage more students to consider rural family practice.

Pay physicians for supervision and management, e.g., providing home health care ser-

vices.

 Earlier in the process, gather more input from rural physicians and the community on new Medicare methodologies and regulatory changes earlier in the process.

The AMA Councils on Medical Service and Medical Education and three study groups are now investigating recommendations com-

ing out of the conference.

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Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressurelowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Advarse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.8%), clay (1.6%), edema (1.8%), advanced (1.6%), particular (1.6%), edema (1.8%), advanced (1.6%), fushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic lieus. The (1.6%), fushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic lieus. The causal relationship is uncertain anging appetroris, atrioventricular dissociation, chest pain, claudication, mycardial infarction, palpitations, purpura (vasculitis), synocype, diarrise, adv ym outh, gastrointestinal distress, gingval hyperplasia, ecchymosis or brusing, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthraliga and rash, exanthema, hair loss, hyperkeratosis, macules, weeping, urticans, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

Address medical inquiries to: G.D. Searle & Co. Medical & Scientific Information Department 4901 Searle Parkway Skokie, IL 60077

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IowaMedicine

April 1992

Journal of the Iowa Medical Society



Our annual look at the U. of I. College of Medicine ... Learn about innovations that may affect YOUR specialty!

Plan 5500s Initial Plan Funding Schedule easibility Design InstruВ Study ments Comput-Plan Plan erized Consul-Amend-Installa tation Valuation ments tions

Here's the Complete Pension Package You Can Establish with Complete Confidence

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Stephen D. Roe Pension Consultant 3737 Westown Parkway, Suite E West Des Moines, IA 50265 (515) 224-0073



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See DOSAGE AND ADMINISTRATION section of prescribing information.

ilf, after an adequate trial of ACCUPRIL alone, based on your medical judgment as the prescribing physician, you determine that your patient requires the addition of a diuretic. Parke-Davis will refund to the patient his her cost for the diuretic prescription less any amount reimbursed or paid for by an HMO, insurance company, or any other plan or program For more details, ask your Parke-Davis Representative or call 1-800-955-3077.

In some patients, the antihypertensive effect may diminish toward the end of the once-daily dosing interval. In such patients, an increase in dosage or twice-daily administration may be warranted.

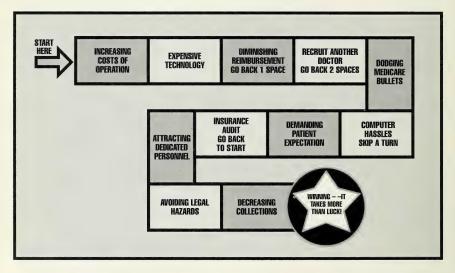
ACCUPRIL is available in 10, 20, and 40 mg tablets. Usual initial starting dosage is 10 mg once daily.

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Please see brief summary of prescribing information on following page



DOCTOR, YOUR PRACTICE CAN SURVIVE THEM ALL



Your manager is indispensable. The health of your practice depends, in a real measure, on the performance of this individual and the rest of your staff.

You should know that the Iowa Medical Group Management Association (IMGMA) is an organization with over 400 members. IMGMA is committed to educating its members and elevating their job performance.

We invite and encourage your support of IMGMA and its activities. We are happy to supply information about membership requirements and the scope of our program.

Doctor, we're in the game with you.

IOWA MEDICAL GROUP MANAGEMENT ASSOCIATION



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President's Privilege



R. Bruce Trimble, M.D.

Quality

"A hallmark of any profession is the privilege of standard-setting and the concomitant willingness to be measured against these standards."—J.R. Ball, M.D., J.D., executive vice president, American College of Physicians

"Problems in cost, quality and access are interconnected."—Iowa Leadership Consortium on Health Care

MEDISGROUPS SYSTEMS ARE COLLECTING data in all the larger Iowa hospitals. JCAHO is revamping its accreditation procedures to focus on quality assurance. Many specialty societies are developing practice parameters. An IMS committee will report in next month's IOWA MEDICINE on its small area analysis projects. Some hospitals and groups are discussing implementation of a system called Constant Quality Improvement developed by Walter Deming.

What's going on?

We have always spent much time—from CPC to CME to hospital review—on quality assurance and improvement. New tools and concepts such as those noted above should make our efforts more interesting and more useful.

Some of these tools, like small-area analysis, can be used now. Others such as practice protocols and useful outcome measures are still undergoing refinement. But all the tools will improve. They can add to our competence and to the enjoyment of our practices. They can also help assure ourselves, patients and payors that our practice patterns are appropriate and cost-effective.

Payors and policy makers appreciate this potential. They are well aware of the demonstrations by Walter Deming and other experts in industrial quality management, that an emphasis on quality also results in lower costs. Some public assessment efforts, such as those of the Iowa Data Commission and HCFA's mortality data, may so far be primi-

tive, but they too will improve.

Physicians should lead in using and explaining these tools. Objective quality measurement may never work quite so well in medicine as in the factory. Only physicians can answer questions the data raise, assure that numbers are not put on that which cannot be quantified and ensure these techniques are used not just to finger-point and cut services but to improve care.



FOR THE PRACTICING PRIMARY CARE PHYSICIAN MAY 9, 1992 **COLLINS PLAZA HOTEL** CEDAR RAPIDS, IOWA

Keynote Speakers

Bruce F. Waller, M.D., F.A.C.C. John Eric Deanfield, M.D.

Keynote Speakers

James R. Pluth, M.D. Michael B. Hill, M.D., F.A.C.E.P

— Course Objectives and Intended Audience —

This course is designed to provide family practitioners, internists, other primary care physicians and nurses with practical approaches to common cardiovascular disorders. The course will emphasize diagnostic evaluation, treatment modalities and day-to-day management of these disorders from the perspective of the primary care physician.

Agenda

7:30	Registration

- Opening Remarks Dr. James Levett
- 8:15 Surgical challenges in the treatment of coronary artery disease - Dr. James Pluth
- 9:00 Controversies in the management of silent ischemia
- Dr. Eric Deanfield 9:45 Question Session
- 10:15 Break
- The current role of nuclear testing in the evaluation of the 10:30 cardiac patient - Dr. John Floyd
- 11:15 Identification of the young patient at risk for sudden cardiac
- death Dr. Bruce Waller
- 12:00 Question Session
- 12:30 Lunch
 - Perspectives on medical practice in the Soviet Union - Dr. William Meffert
- 1:30 Update on the National Heart Attack Risk Study - Maurita Soukup, RN, CCRN, D.N.SC
- 1:45 Failure to diagnose acute myocardial infarction -Legal issues - Dr. Michael Hill

Concurrent Workshops

- 2:30 - Auscultation of heart sounds - Dr. Clarence Shub and Dr. John Stokes
 - Legal issues case presentations Dr. Michael Hill New cardiac medications -
- Which drug for your patient Dr. Lawrence Cook 3:15 Break

3:30

- Auscultation of heart sounds Dr. Clarence Shub and Dr. John Stokes
- Medical case studies Dr. A. Ersin Atay Cardiac pacing in the 90's - Linda Mavity, RN 4:15 Evaluations

Accreditation -

CME: As an organization accredited by the Iowa Medical Society for continuing medical education, the Cedar Rapids Medical Education Program certifies that this CME offering meets the criteria for 8 Credit Hours in Category 1, provided it is used and completed as designated.

American Academy of Family Physicians: Credit hours for the American Academy of Family Physicians has been applied for.

American Osteopathic Association guidelines for continuing medical education has indicated that this program is eligible for 7 credit hour(s) in Category 2-A.

Risk Management: The two presentations by Dr. Michael Hill have been approved for 2 hours of risk management credit towards Iowa Physicians Mutual Insurance Trust's educational requirement.

CEU: 0.8 CEUs will be awarded upon full completion of the program by St. Luke's Hospital, Provider #46. The program meets criteria for the Iowa Board of Nursing Subject Matter 5.3 (2) a (1, 3. & 5). The cost for CEUs is included in the conference fee. Certificates will be awarded at completion of the program. For questions or further information regarding CEU processing or grievance policies contact Sandra D. Vanourny at St. Luke's Hospital, 319-369-7500.

Registration Fee

Physician-\$50.00

Residents & Nurses-25.00

(includes course materials, breakfast, lunch and refreshments)

Registration Deadline is May 1, 1992. Registration is limited. For registration information please contact June Zenisek, R.N., Symposium Coordinator, 319-362-5118 or 1-800-728-5118

The Editor Comments



Marion E. Alberts, M.D.

Heirs of Hippocrates

ANY IOWA PHYSICIANS, I am sure, are not aware of the great collection of historic medical books in the Hardin Library for the Health Sciences at the U. of I. College of Medicine. The immensity of the collection is demonstrated by the recent publication of the third edition of the catalogue titled *Heirs of Hippocrates*. The presentation of 2,339 historical works of medical literature can be read as a history of medicine. The entries include a brief note about the author and his works; all in chronological order based on the author's year of birth.

The forward, by the late Dr. William B. Bean, emphasizes the truth that books are "a summary of our culture, our progress as rational beings, our developing spirit of humanism and our desire to aid our fellow men and women." The annotations of the entries of this catalogue do lead us through the exciting story of medicine from Hippocrates (c 460–368 BC) to the present century.

The Hardin Library has been enhanced by the fabulous collection of books provided by Dr. John Martin. As Dr. Martin relates in the introduction of this book, journal articles will assume increasing historical significance since the older, rarer and highly desirable books are more difficult to obtain as they become parts of collections.

Richard Eimas, compiler and editor of this publication, is the curator of the John Martin Rare Book Room. He has completed a monumental work that will become a collector's item. The references cited throughout are of the highest order; they have withstood the test of time. The style and the printing of the text and the numerous illustrations are works of art.

Many students of medicine feel the history of our profession is of no importance. The task of learning the complexities of the art and science of medicine is paramount. Yet, all of us are heirs of Hippocrates and thereby are part of the continuing panorama of medical knowledge. The threads of each contribution by physicians through the years become woven into the tapestry of medical history. Our efforts of today will be read as history by those who succeed us. We must realize and cherish our heritage. Much of what we know today will be proven of useless value . . . mere interesting historical notes.

Heirs of Hippocrates would be an excellent addition to the physician's library. Though the cost is steep (\$125.00) it would be money well spent. The history of medicine is great reading, and this volume will provide much reference material.

Eimas, Richard, editor, *Heirs of Hippocrates*, 1990, University of Iowa Press, Iowa City, 705 pages, \$125.00.



The Throckmorton Surgical Society **Spring Meeting**



Surgical Symposium on Laparoscopic and Endoscopic Procedures

May 1-2, 1992

Iowa Methodist Medical Center • Jester Auditorium

Des Moines, Iowa

Guest Faculty

George Berci, M.D. Senior Consultant of Surgery Clinical Professor of Surgery (Em.)

UCLA School of Medicine

Charles J. Filipi, M.D. Assistant Clinical Professor of Surgery Creighton University School of Medicine

Robert J. Fitzgibbons, Jr., M.D. Associate Professor of Surgery Chief of Division of Surgery Creighton University School of Medicine Ralph Ger, M.D.

Nice, France

Professor, Surgery and Anatomy Chairman, Department of Surgery Winthrop-University Hospital

Docteur Namir Katkhouda Chief of Surgical Endoscopy Hospital St.-Roch

J. Barry McKernan, M.D., Ph.D. Professor of Surgery University of Kentucky

Victor F. Trastek, M.D. Consultant Section of General Thoracic Surgery Mayo Clinic Associate Professor of Surgery

Mayo School of Medicine Karl A. Zucker, M.D.

Associate Professor of Surgery The University of Maryland School of Medicine

Topics

- Advanced Procedures and the Outlook for the Future in Laparoscopic Surgery
- Anatomy and Laparoscopic Treatment of Groin Hernias
- Colon Resection
- Common Bile Duct Exploration
- Dealing with Problems During Laparoscopic Cholecystectomy
- Duodenal Ulcers—Vagotomy; Seromyotomy
- Emergency Laparoscopy in Blunt Abdominal Trauma and in Obscure Acute Abdomen

- Endoscopic Valvuloplastu
- Esophageal Myotomy
- Highly Selective Vagotomy
- Laparoscopic Appendectomy and Adhesiolysis
- Laparoscopic Cholecystectomy in France
- Laparoscopic Inquinal Hernia: Current Status
- Laparoscopy for Surgeons: Role in Oncology Cases, Diagnosis and Staging
- Nissen Fundoplication
- Video Thoracic Surgery: Indications, Techniques and Results

Accreditation

As an organization accredited for Continuing Medical Education, the Iowa Methodist Medical Center certifies that this CME program meets the

criteria on May 1st for 6 hours and on May 2nd for 21/2 hours in Category I of the Physicians Recognition Award of the AMA.

Cost

Contact

Surgical Education Office Iowa Methodist Medical Center 1200 Pleasant Street Des Moines, Iowa 50309 (515) 241-6076

A different perspective on changing times

Dr. James Clifton, interim dean of the U. of I. College of Medicine, says enhancing Iowa's health care system is a top priority for the college.

IN AN INTERIM DEANSHIP—to which one can hardly aspire nor specifically prepare for—one notices how often new perspectives open on an environment one might easily take for granted after living in it nearly 45 years.

I hope the insights into the College of Medicine and the University Hospitals and Clinics we present in this issue of *IOWA MEDICINE* will give to you that sense of new perspectives that my "interimship" gives me.

While not all our departments are featured, those included are highly representative of the urge to teach, the quest for a better way and the search for new answers that characterizes them all. It is inspiring to have the broad view of the interaction among 600 faculty members, 700 medical students and hundreds more students from other parts of the University as they go about their daily activities in a first-rate academic medical center.

From my temporary outpost, I have gained new perspectives even on matters that are in reprise, such as the resurgence of concern for primary care. This leads us to reflect on the steps the College has taken over the years to meet this important need. It was nearly twenty years ago the College and members of the General Assembly worked together to create the Statewide Family Practice Training Program. This program is familiar to readers of this journal, of course, but perhaps the broader record of the College of Medicine's activity is not.

James Clifton, M.D.



For example, as our programs move ahead we find that nearly half the student preceptorships in the past 10 years have been in Iowa towns with populations under 10,000 (35% of our students now come from communities of this size). A preceptorship with a family practitioner is a requirement for all third-year medical students. In what has been a steady progression, we also find that new M.D.s from the College of Medicine enter family medicine at nearly twice the national rate.

Our medical education committee has begun its periodic review of the undergraduate curriculum. A fundamentally important task, curriculum development is difficult and requires participants to be aware of the needs

of students and of societal conditions that may influence our students as practitioners.

Another perspective on the College of Medicine and its relationship to medical practice in Iowa is that 50% of all Iowa practitioners are our medical graduates or have had some form of graduate medical education through our system. I assure you the College gives its highest priority to enhancing our state's health care system.

The Office of Community-Based Programs in the College of Medicine coordinates the Statewide Family Practice Program and much more (including technical assistance such as physician placement and practice management advice) in our efforts to help Iowa communities gain and retain residency graduates. Representatives of the communitybased programs office visited 194 Iowa cities and towns in recent years to provide assistance as well as gain insights into how better we may serve.

As you read the various commentaries from the College herein, if you have questions or comments please let us know. Your

perspectives are valued, as always.

The Iowa Summer Writing Festival presents

Creative Writing in the Professions

week of June 7-12, 1991

A special week of the Iowa Summer Writing Festival set aside especially for persons in the field of

Health

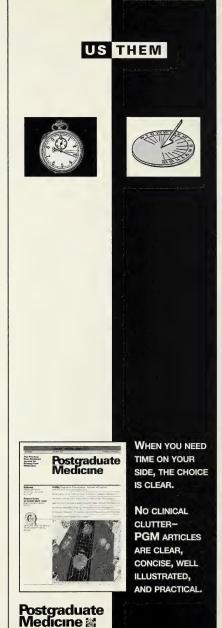
as well as for professionals in Religion • Law • Social Work

A unique opportunity to workshop and discuss creative writing with those who share your vocation and your avocation

No previous writing experience necessary All workshops are non-credit

> For more information, contact: Peggy Houston and Karen Burgus Division of Continuing Education 116M International Center Iowa City, IA 52242 (319)335-2534

> > The University of Iowa



CME in the comfort of your home

A compact disc player and a remote control may be all the physician of the future will need to keep up with continuing medical education.

Robert Folberg, M.D.

Iowa City, Iowa

IMAGINE BEING ABLE TO KEEP UP with your continuing medical education using a compact disc player and a remote control in the comfort of your own home.

The screen comes to life and a menu appears. With the remote control a topic is selected—a cardiology update, for example—in which heart sounds are presented with the clarity of compact disc stereo while electrocardiograms, echocardiographs, angiograms and other visual data are displayed. The program offers a quiz for self assessment. If the player is con-



Dr. Folberg demonstrates use of the wireless joystick to control instructional material on CD-interactive disk.

Dr. Folberg is with the University of Iowa College of Medicine Department of Ophthalmology.

nected to a telephone line, the quiz answers can be sent off to be scored for continuing medical education credits.

A scene from the distant future? Not really. The technology, *Compact Disc-Interactive* (CD-I), developed by Philips Consumer Electronics and Sony and introduced in the U.S. last October, seamlessly integrates pictures and sound and puts everything under the operator's control at a fraction of the cost of a computer. Dozens of CD-I titles are already available in Iowa, including interactive Sesame Street for children, games and a complete tour of the Smithsonian Museums in Washington, D.C. Audio CD's can be used in the CD-I player unit. Future enhancements will include the ability to display photographs using the Kodak Photo CD.

Development of CME programs

Programs for physicians and patients are now being developed by the Educational Resources Group, a division of the Department of Ophthalmology at the University of Iowa. This group has four years' experience developing interactive computer programs for medicine. For physicians, learning from CD-I may be more practical because with a videotape, the user cannot select topics for study because fast forward and reverse are the only options. Also, CD-I is more economical than a computer and computer literacy is not needed to operate a CD-I player. Finally, unlike the VCR, there is nothing the user must program.

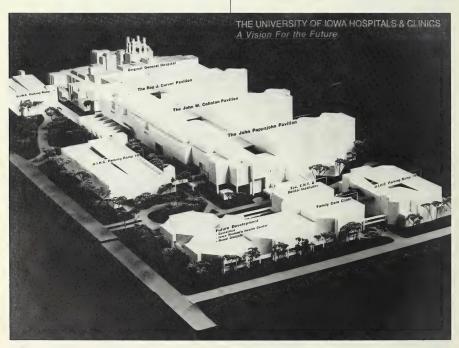
Full-motion video soon will be available for CD-I players; the entertainment industry is already gearing up to take advantage of this. Full-motion video means, for example, that the surgeon can step through an operation on a home television set by choosing a course of action and watching the result. Obstetricians may be able to manage complicated deliveries and observe the outcome of different strategies and decisions.

CD-I is ideal for patient instruction. Imagine introducing a new diabetic patient to diet and insulin therapy using CD-I and a television, either in the clinic or in the patient's home. To ensure the patient really understands the instructions, an educational

CD-I game can "test" the patient for comprehension.

Is language a problem? One CD-I disc can provide medical education in many languages (a perfect medium for educating physicians and patients in Third-World countries). Not everyone can own or operate a computer, but almost every one can operate a television set.

The CD-I programs in process at the University of Iowa use special software tools developed by two Des Moines-based companies. This strategic partnership between the University of Iowa and Iowa business means Iowans could become pioneers in the delivery of medical education.



Future enhancements of patient care services at the University of Iowa Hospitals and Clinics ensures continued tertiary care support for Iowa physicians and their patients. A final increment in University Hospitals' capital replacement program is being developed. A new Eye Institute building to be located south of the John Pappajohn Pavilion and linked by an overhead walkway will replace outmoded accommodations in the 1926-vintage General Hospital building. "Our faculty, staff and our patients are very excited about this," said Thomas Weingeist, M.D., professor and head of the Department of Ophthalmology. "This department is recognized among the top in the nation, but our success has outpaced our capacity to serve our patients in an uncrowded setting." Planning for the Eye Institute will also include the development of a replacement Ear, Nose and Throat and Dental Institute and Family Care and Geriatric Clinics. An Iowa Women's Health Care Center and a fourth parking ramp will be part of the completed project.

Research, innovations continue at UI College of Medicine

Physicians representing ten departments in the University of Iowa College of Medicine discuss new technologies and techniques in their specialties.

Neurology: a changing role

Antonio Damasio, M.D., Ph.D.Head, Department of Neurology

FOR MORE THAN A CENTURY neurology has been a key discipline in medical practice. Perhaps this is because the central and peripheral nervous systems are affected both by primary neural diseases and by diseases of many other organs and systems and thus call undue attention to themselves. The anatomy, physiology and pathology of neural tissues are so unlike those of other systems that they require specific diagnostic tools and particular modes of intellectual approach.

Neurology's role in health care is changing for several reasons. First, the aging of the population and the appearance of new diseases have increased demand for neurological services. Many neurological diseases such as stroke, brain tumors and degenerative diseases are more common in older people.

For instance, not only do we have more patients with movement disorders such as Parkinson's disease, we are also in the midst of a virtual epidemic of a most disabling condition: Alzheimer's disease. Another source of increased demand comes from the spread of AIDS, an illness that almost always has an impact on the nervous system.

Growth of neuroscience

A second reason for a change in neurology is the evolution of neuroscience, which has been in a state of exponential growth for two decades. The 1990s is the Decade of the Brain, naturally and by presidential decree, and the consequences of the expansion are now being felt in the clinical front.

The approach to neurological illnesses is changing dramatically as a result of scientific developments and neurologists are playing a larger role in the investigation of neurological diseases. New laboratory techniques (linked, at one end, to molecular biology and, at the other, to imaging technologies such as magnetic resonance and positron emission tomography), allow us to conduct basic science studies in living humans. The net result is an increased demand for clinical and scientific expertise and a challenge for academic departments of neurology in which neurologists are called to practice, conduct research and teach.

The challenge is especially great in the 1990s, now that health care and scientific funding are at a crossroads. How can neurologists incorporate the new advances in neuroscience in a competent and compassionate practice at a time of economic stress? How can neurologists ensure that the flow of new research findings does not stop? At Iowa our response to the challenge has been to commit ourselves to both neurological care and neuroscientific investigation. We believe it is necessary to maintain superlative neurology practice and a superior neuroscience program. To achieve this we have enlarged the compass of subspecialty academic groups. In addition to stroke, epilepsy, behavioral neu-



Antonio Damasio, M.D. Neurology



Robert Wallace, M.D. Preventive Medicine and Environmental Health



Frank Morriss, Jr., M.D. Pediatrics



Charles Driscoll, M.D. Family Practice

rology and neuromuscular diseases, there are units dealing with pain management, neurooncology, sleep, neuroimmunological disorders and neuro-ophthalmology.

Neurology has a distinguished tradition at the UI. Our department is one of the three oldest in the nation, having opened 72 years ago shortly after Harvard's and Columbia's.

Preventive medicine/ environmental health: reaching across lowa

Robert Wallace, M.D.

Head, Department of Preventive Medicine and Environmental Health

IOWA PHYSICIANS WILL BE INCREASINGLY aware of the Department of Preventive Medicine and Environmental Health through activities that go beyond Iowa City.

For example, we will seek increased affiliation with community physicians and health care institutions in development of preventive services. Activities include increasing industrial hygiene consultation with local industry to increase our health research base and further developing community situations for the industrial hygiene training program.

The largest departmental growth will be reflected in programs that define the causes of, and institute preventive and control measures for, problems such as coronary heart disease and stroke, cancer, birth defects, mental illness, the disabling conditions of aging, and hazards of pollution in the workplace and rural areas.

Other measures the department expects to implement over the next five years include:

• Increased research on preventive services and health promotion among the rural elderly, including community studies of optimal ways to deliver preventive services. This is complemented by increased geriatric prevention education of medical students.

• Additional community-based clinical trials for prevention of chronic disease. Examples of this over the next several years include medication to prevent osteoporosis and coronary disease in women and dietary alterations for cancer and heart disease prevention. The department continues to grow as a national resource for coordination and data management of large clinical trials.

 Continued development of statewide registration of incident diseases such as cancer, birth defects and dementia. This will serve as a resource for Iowa physicians.

 Continued fostering of international education, such as the sponsorship of medical students for Third World health care experiences and the study of comparative health systems.

• Further development of academic resources for both research and teaching with respect to the economic analysis of medical practice.

• Incorporation of the teaching of modern preventive practices into the clinical curriculum. While most formal prevention instruction remains didactic, the department intends in the future to incorporate preventive skills into clinical clerkships.

 Increased involvement in research on the genetic causes of disease and quantitative



Jennifer Niebyl, M.D. OB/GYN



Frederick Dietz, M.D. Orthopaedic Surgery



Stuart Weinstein, M.D. Orthopaedic Surgery



E. A. Franken, Jr., M.D. Radiology

genetic analysis, including a departmental interest in both the genetic and environmental causes of heart defects, obesity and cleft lip and palate.

Pediatrics: a look ahead

Frank Morriss, Jr., M.D.Head, Department of Pediatrics

THESE DEVELOPMENTS WILL OCCUR in the next four years: more children with HIV infection and AIDS; better testing for genetically inherited diseases and improved opportunities for preventing such diseases; emergence of molecular biotechnology useful in treating pediatric disorders; and expanded application of behavioral interventions for a spectrum of frustrating problems.

Other developments, less certain but likely, include: additional inhaled medications for pulmonary disorders; wider application of bone marrow transplantation to treat non-oncologic disorders; definitive, rapid diagnosis by molecular biologic techniques; and increased morbidity resulting from lack of timely access to care and/or "social ills" such as substance abuse, dysfunctional families, child abuse, sexual abuse, neglect and sexually transmitted diseases.

A third group of developments might be reasonably hoped for within five years: new therapies for cystic fibrosis arising from isolation of the CF gene and identification of causative mutations; immunizations against diseases such as varicella, group B streptococal perinatal infections, HIV; and a system of health care delivery that provides all children

with preventive care, health maintenance and acute and chronic disease care.

Perinatal AIDS to increase

The most rapidly rising subgroup of HIV-infected patients are women and infants who have acquired infection vertically from HIV-positive mothers. In a society in which persons at risk are unaware of their HIV status, who can argue that perinatally acquired HIV-infected infants will not increase? If current trends continue, AIDS will soon become one of the five leading causes of death in the pediatric age group, says a report from the U.S. Department of Health and Human Services.

No other area of biomedical research is moving as fast as is molecular genetics. We've taken on the challenge to map the human genome and disease-related genes are among the first to be mapped. The ability to detect single base pair mutations in DNA makes possible the identification of patients, including fetal patients, who carry the gene for a particular disorder, as well as to detect carriers. Researchers in the Department of Pediatrics identified novel mutations in the rhodopsin gene that are associated with autosomal dominant retinitis pigmentosa.3 They have been able to correlate various rhodopsin gene mutations with clinical phenotypes. Such correlations will lead to more accurate diagnoses and better counseling. Similar work is being conducted within this department with the various phenotypes of osteogenesis imperfecta and with genetic mutations responsible for the 21-hydroxylase deficiency, one cause of congenital adrenal hyperplasia.4,5



W. John Sharp, M.D. Surgery



Francois Abboud, M.D. Internal Medicine



Thomas Weingeist, M.D. Ophthalmology

Promising biotechnology

Among the new products of biotechnology with promising therapeutic uses is recombinant human erythropoietin. The Department of Pediatrics is involved in research that has improved understanding of erythropoietin physiology and pathophysiology in the fetus and newborn and of the conditions necessary for its therapeutic effect. Researchers are studying the efficacy of erythropoietin in reducing the next for erythrocyte transfusions in anemic, very low birthweight infants. Other promising biotechnology products include monoclonal antibacterial antibodies and cytokines, both of which hold promise for treatment of overwhelming sepsis.

A large portion of morbidity arises in part from adverse behaviors. Some thoughtful clinicians have investigated the reasons for adverse behaviors that contribute to disease and they are testing interventions to change the adverse behaviors.

For example, obesity and smoking are risks for coronary artery disease that begin in childhood. In addition to smoking cessation and nutritional counseling interventions, staff with the Department of Pediatrics are seeking to identify genes associated with obesity to better understand and target patients for dietary interventions. Others are investigating the reasons young urban women engage in unsafe sex, a practice that places them at high risk for HIV infection. Finally, a behavioral assessment methodology has been developed for children who engage in self-injurious behavior or those with feeding disturbances.⁸

(References are available from the author or the editors of IOWA MEDICINE).

Family practice: a widening scope of practice

Charles Driscoll, M.D.

Head, Department of Family Practice

MEDICINE TODAY IS CHARACTERIZED BY continual change. Health care cost escalation captures the attention of professionals and solutions to what *Time Magazine* called the "health care mess" are coming fast and furious from all directions. Prognosticating what will reshape Iowa medicine is somewhat like standing in shifting sand.

Ambulatory health care education

The health care system is being reorganized around ambulatory services and away from hospital care. Most forces that propel this reorganization are from outside the profession, principally third-party payors.

One of the most important initiatives in medical education is a shift toward primary health care in an outpatient setting. We can expect to see continued curricular innovation and new ways to train medical students and residents in ambulatory settings where efficiency and enthusiasm for primary care medicine can be engendered.

It is also likely that a shift of technology will need to occur to advance the capabilities of primary care physicians. Procedural skills such as colposcopy and endoscopy will shift from secondary/tertiary level practitioners to primary care physicians. RBRVS reimbursement reform may provide some momentum for this as procedural skills become less financially rewarding. For earlier disease de-

tection and intervention, first contact physicians certainly must have better training in the performance of diagnostic procedures. The primary care physician of the future likely will be backed up by regional consultants via two-way interactive video medicine conveyed by fiber-optic communication circuits. This may make "rural isolation" an archaic phrase.

Scope of practice in primary care

Of several areas of medical practice that will grow in importance, the most obvious is primary care management of HIV disease. Iowa physicians now see increasing numbers of HIV positive patients with no cure in sight. New doctor-patient interpersonal skills may be needed to help our patients cope with the inevitable.

A core of knowledge about AIDS will be hard to maintain without the use of an office-based computer. Personal computers will call up the rapidly changing literature on this subject via modem access to data centers and computer-assisted diagnostic and treatment protocols will be available. Developments will be too rapid to rely on printed literature alone.

Other areas receiving more attention will be environmental medicine and aging. The diverse problems of poverty, drug abuse, pollution and global warming are parts of our social and ecological environment. These factors will cause diseases demanding new skills and management strategies from primary care physicians. By the year 2000 nearly 20% of the U.S. population will be 65 or older, requiring greater focus on chronic and degenerative diseases. Coordination of health services at the local and regional level will become even more important.

The red tape factor

Physicians may see increasing outside influences on office practice, at least in the short term. New Medicare coding schedules, office-based visit-related groupings similar to DRG's and mandatory quality-assurance reviews of office care are just a few examples that come to mind.

What lies ahead in Iowa's medical future? You may have your own guess and it is as good as ours. We are optimistic that the good will outweigh the bad and this profession will continue to be a satisfying career, a

message that needs to be conveyed to new physicians and talented students who may be interested in becoming physicians. Generalist physicians will be better trained and better supported in rural practice; increasing their numbers should continue to be a priority.

Obstetrics/gynecology: looking ahead

Jennifer Niebyl, M.D.

Head, Department of Obstetrics and Gynecology

WE CAN BE REASONABLY SURE substantial progress will be made in general gynecology, hormonal replacement therapy, gynecologic oncology, urogynecology, reproductive endocrinology and maternal-fetal medicine.

General gynecology

In this area, a major trend is increasing reliance on ambulatory and outpatient care, with increasing use of laparoscopy. There will also be more emphasis on preventive rather than interventional medicine. The "consumerization" of women's health care and patterns of third-party payment are likely to result in fewer hysterectomies.

Women who once underwent hysterectomies for heavy bleeding and severe menstrual cramps are now managed with prostaglandin synthetase inhibitors. Those for whom medical management has not been successful may undergo endometrial ablation to decrease menstrual bleeding.

Research will continue into new forms of birth control such as the latest, Norplant. Long-term, reversible forms of contraception with minimal side effects are on the horizon.

Tests are underway involving 1,000 healthy women to investigate hormone replacement therapy after menopause. The effects on the heart of five different treatment regimens will be charted.

The proportion of women who have used hormones for at least 10 years is about 10-15% compared with only about 5% a few years ago. With the information being generated in research studies, it will be much easier five years from now for women to make

informed decisions about hormonal therapy. There will probably be an increase in the number of women using hormones.

Other drug research will explore the safety of taking hormones after breast cancer treatments. Currently, hormones aren't used because hormones and estrogens could cause recurrence of the cancer.

More knowledge about treatment for premenstrual syndrome should come in the next five years.

Gynecologic oncology

Within five years, it is biologically possible that vaginal ultrasound screening with color flow doppler will permit screening for ovarian cancer. It shows potential for early detection of some ovarian cancers.

Doppler studies in conjunction with various serum tumor markers to increase the sensitivity of screening are underway. An active area of investigation is familial cancer and the responsible genes could be isolated in the next five years.

Urogynecology

We can expect to see new treatment options for urinary incontinence and urogenital prolapse. Research in this area is focusing on medical and nonsurgical therapies that include behavioral training, medications, use of vaginal devices, urethral plugs and pelvic muscle floor exercises. Also under investigation is the use of collagen injections to treat stress incontinence for women who cannot undergo surgery.

Reproductive endocrinology

In the area of *in vitro* fertilization, the future will center around the search for improvements in treating sperm problems, improving embryo culture and development of techniques to place sperm in the egg. There will be increased use of donor eggs.

Increased use of laparoscopic and hysteroscopic surgery can be expected in reproductive endocrinology, as well as increased use of ultrasound for diagnosis and therapeutic procedures. Treatment of ectopic pregnancies by medical therapy is on the horizon.

Maternal fetal medicine

Fetal medicine is undergoing dramatic changes that will allow for more disorders to

be diagnosed and treated in fetal stages before birth.

Research will be directed toward drug abuse in pregnancy and the spread of HIV.

Prematurity remains a major obstetrical problem. Research will focus on the development of drugs to stop preterm labor and ways to prevent preterm labor.

Complications such as ectopic pregnancies can be managed through laparoscopic surgery. The pregnancy is removed through a very small incision. Obviously, recovery time is much quicker.

The specialty

The trend for more women to enter the specialty of obstetrics and gynecology will probably continue. Over half of last year's graduating senior residents in ob-gyn were women. In the next five to 10 years this will mean a demographic shift in the gender makeup of ob-gyn practitioners. The numbers of women in the specialty and of those who ultimately become teachers may accelerate attention to conservative management options and preventive medicine.

Orthopaedic surgery: improving patients' lives

Frederick Dietz, M.D. Stuart Weinstein, M.D.

Department of Orthopaedic Surgery

CONTINUING RESEARCH AND APPLICATION in orthopedic surgery will involve surgical procedures, instrumentation used in research, surgery and treatment, improved means of limb lengthening and introduction of new composite materials for hip stems.

In the area of spinal deformity correction there has been rapid growth in new instrumentation systems that permit superior corrections as well as much shorter bed-rest periods in recovery. Today the majority of patients are up within 24 hours following surgery.

Further improvements in the ability to monitor spinal cord function during surgery are expected to follow pioneering techniques recently developed through the electro-physiology division of the University of Iowa Department of Neurology. Another area that will develop rapidly in the future and has already made a great difference to patients is the ability to correct limb, angulatory and rotatory deformity and limb lengthening.

Promising tool

A new research tool of great potential in orthopedics is the computer-based pedobarograph at University of Iowa Hospitals and Clinics. A device for measuring the distribution of pressure under the sole of the foot, it can record and evaluate dynamic distribution of this pressure very precisely. Two measuring devices are used: a platform over which one walks and an electronic insole worn in a shoe.

The device gathers pressure measurements during walking, running and even in high-speed athletic activities. It will display on a monitor and a printed sheet the location and intensities of pressure in two views. One is a full footprint and the other a three-di-



Foot pressure on electronic platform of pedobarograph is portrayed in 3-D on monitor.

mensional "landscape" in which relative pressure is shown by the height of lines. In both views the degree of pressure is shown through color coding ranging from white at the low end to red at the high.

It is currently used to evaluate deformed feet, both pre- and post-operatively and to better assess how well surgical treatment improves the foot and what deformities remain. It is also used to assess outcomes of foot deformities treated many years ago. Many other aspects of study, such as the loss of sensation in the foot due to diabetes, will be aided by this equipment.

Radiology: exciting advances

E. A. Franken, Jr., M.D.

Head, Department of Radiology

RADIOLOGY ANTICIPATES EXCITING advances in patient care, research and education in the near future.

Patient care

Clinical applications of imaging and treatment tools will be broadened, especially with magnetic resonance imaging (MRI) and positron emission tomography (PET). New applications for MRI will be explored. Large-vessel angiography has the greatest potential for clinical use in the near future.

In the next several years, MR tissue characterization will likely replace many current diagnostic procedures. Advancements in MRI will bring new contrast media, three-dimensional reformatting and dynamic scanning. Magnetic spectroscopy is an emerging tool whose applications will become apparent particularly in a stroke, cancer and heart disease analysis.

PET, which can determine metabolic function at the cellular level, is expected to advance characterization of heart disease, diagnosis of neuropsychiatric disorders and detection and management of cancer.

Also emerging in radiologic techniques for routine diagnosis and treatment are thin section CT for anatomic and functional lung imaging and screening for asymptomatic coronary heart disease with fast CT. With rapid

improvements in cytopathology and needle localization techniques, CT will be used for biopsies. In breast imaging, ultrasound for diagnostic purposes will become more prevalent as will new mammographic devices to stereotactic biopsies.

Better imaging

Single-photon tomography will continue to improve the characterization of brain perfusion and metabolism. Better definition of myocardial perfusion will be possible with better radiotracers, instrumentation and data processors for signal attenuation. And there will be more effective screening techniques for renovascular disease as a cause of hypertension.

Electronic transmission of images from one site to another will grow. It is apparent that teleradiology has the potential to improve the access and quality of patient care, particularly in remote rural areas.

In radiation oncology, stereotactic radiosurgery shows great promise over conventional radiation therapy. It delivers radiation from all angles and thereby provides a higher dosage to the tumor, without damaging the surrounding cells. Automated afterloading systems and hyperthermia machines will become more prevalent in radiation treatment.

Research

New applications for MRI, magnetic spectroscopy, CT and PET will be sought. Investigative work in MR includes finding new contrast agents and looking at the effects of MR contrast media in order to determine optimal dosage levels in diagnostic procedures. CT used in conjunction with a cancer treatment planning computer permits more accurate mapping of dosage and location of radiation. The dosimetry system projects a three-dimensional image on a screen to identify different levels of radiation in various anatomical regions. Preliminary results indicate the system has great potential in more effective radiation treatment.

The unique capabilities of PET allow investigations into new areas such as defining abnormal brain responses to physiologic and cognitive challenges. Because PET measures metabolic changes in the brain, it provides earlier diagnosis and treatment for a number of disorders that cannot be detected by CT or MRI. Similarly, based on the higher rate of

metabolic rate in abnormal cells, PET can be used to monitor response to therapies. Still another possible application of PET is to monitor toxic effects of chemotherapy on normal tissues.

Finally, a relatively new area of research involves assessing clinical utility and appropriate uses of electronic imaging. Investigations include looking at the value of teleradiology in clinical settings and assessing the quality of images between those transmitted electronically and the original plain films.

Education

Radiologists are studying the efficacy of teaching with video images rather than film images. An interactive computer-based educational module is being explored as a potential teaching tool. New approaches to medical student education and residency selection continue to be evaluated.

Surgery: rapid progress

W. John Sharp, M.D. Department of Surgery

ASCULAR SURGERY HAS SEEN rapid progress in the past three decades and a technologic explosion in the last five years. Yet, maintaining the quest for knowledge and delivering the best possible health care doesn't always mean providing patients with (or subjecting them to) the most recent technologic developments. Rather, it means keeping abreast of developments and trends so that we may appropriately counsel and treat our patients.

Cerebrovascular disease

Surgical treatment of carotid disease has been heavily criticized and closely scrutinized. Vascular surgeons have long felt that certain patients received lasting benefits from carotid endarterectomy.

Recently a large multicenter trial confirmed that patients so treated fared better than their medically treated counterparts when there was a high grade symptomatic stenosis. We await the results of two other important subgroup studies of high grade asymptomatic and lower grade symptomatic lesions. Increasing interest in the endovascular treatment of carotid artery lesions such as balloon angioplasty should be viewed with a great deal of caution considering the end organ involved. For now, carotid endarterectomy remains a safe and proven method of treating properly selected patients with significant cerebrovascular occlusive disease.

Aortic aneurysm

Recently, there have been major advances in perioperative care of abdominal aortic aneurysm. This has reduced operative mortality to nearly negligible levels. In turn we are now faced with an aging population with smaller aneurysms (which can and do rupture) often requiring difficult therapeutic decisions and a reasoned judgement.

Experienced vascular surgeons can safely repair these aneurysms in all but the most compromised patient. The potential for endovascular repair of aortic aneurysms is currently experimental and awaits further development and careful study.

Lower extremity occlusive disease

Limb salvage remains a very controversial area in vascular surgery. There exists a notion that many, if not most, limb salvage operations result in limb loss after great investments of time and money. This is far from true. Current developments have enabled vascular surgeons to salvage nearly any limb. It is clear that prevention of amputation is one of the greatest contributions of vascular surgery to the aging population. It remains the province of the vascular surgeon to assess each situation and make a judgement as to the benefits of a number of treatment options.

Newer endovascular technologies, though widely applied, have shown significant lasting benefit in only a limited number of patients. Decisions regarding the proper therapeutic approach must be individualized and require judgement and understanding of the specific disease process as well as experience in all the available modalities.

Endovascular surgery

Certainly one of the hottest topics in vascular surgery, endovascular surgery remains an attractive concept. The idea of delivering the therapeutic device directly to the lesion percutaneously has captured the imagination of patient and physician alike. Unfortunately, early evaluation of most of these modalities has not affirmed their usefulness for most types of vascular disease. Nonetheless, noncritical acceptance with the push of technology has made this a popular treatment option.

Realizing that most revascularizations for occlusive vascular disease are procedures that buy time, just how much time one buys with the procedure is an important consideration. To date, most endovascular interventions have not proven as durable as more conventional vascular reconstructions. Undoubtedly, further refinements and new technologies will become available. These should be viewed with a healthy skepticism and tested through scientific study.

Venous disease

Another frontier, venous disease, remains a significant problem in terms of prevalence and consequent disability. Increased awareness and efforts at prevention will hopefully decrease the occurrence of this disease, which usually results from deep venous thrombosis. For now the traditional management of venous insufficiency and complications such as venous stasis ulcer, remain nonoperative except in refractory and unusual cases. Venous valve transplants and valvular reconstructions should still be considered unproven though acceptable options in such refractory cases.

Management of varicose veins continues to evolve and routine stripping of saphenous veins in patients with varicose veins is no longer the standard. Instead, a careful assessment of each patient's problem with an evaluation of their venous hemodynamics to determine the cause of such varicosities is the approach of choice.

In most cases, combined approaches provide superior results in terms of effectiveness and patient acceptance. Injection sclerotherapy has become an effective means of managing many patients with lower extremity varicose and spider veins. As our interest in and understanding of venous disease increases, so should development of effective therapies.

Vascular disease is rampant in our society. Through continuing public education, prevention may become the ultimate therapy for vascular disease.

Internal medicine: making use of research results

Francois Abboud, M.D., B.Ch.
Head, Department of Internal Medicine

INCREASINGLY WE SEE THE IMPACT of research on patient care in the growing sophistication of diagnostic testing and experimental therapy. Research from all disciplines contributes to this trend. In the next five years, technology and information once reserved for specialized research will find their way into the clinician's practice.

Directions in research

Dramatic strides in understanding the immune system will take us closer to identifying effective immune response modifiers and cytokines that can stimulate production or activation of cells that kill tumor cells. Physicians have already begun ordering recently available tests of killer cell function and tests for helper T-lymphocyte function through a new UI cellular immune function laboratory.

Studies involving transgenic animals provide an opportunity to examine human disease processes. Diseases as diverse as cancer, cardiovascular disorders, diabetes and other single gene and multigene disorders are examined using these resources.

A fundamental re-examination of the pathogenesis of tuberculosis will intensify as this disease, thought to have been eliminated,

resurges worldwide.

Strides are being taken in the treatment of ulcerative colitis, a disease for which there have been few treatment options. UI investigators are in drug trials that show promise for a new "designer drug," a 5-lipoxygenase inhibitor. Designed specifically to block the leukotriene pathway that has been implicated in the disease process, this anti-inflammatory may control symptoms with few side effects and without interfering with healing.

Coronary fiberoptic angioscopy will help us to learn more about coronary lesion morphology—information that may ultimately allow better selection of therapy in patients with coronary artery disease.

Other promising studies include investigations into new treatments for hereditary angioedema, clinical evaluation of angiotensin-converting enzyme inhibitors in heart failure and intravascular ultrasound to examine the blood vessel wall.

Directions in patient care

Care for patients with HIV will continue to change. New anti-retroviral agents will become available while combination therapy using two or more of these agents simultaneously or in alternating patterns will become more common.

UI physicians and health professionals have designed a pulmonary rehabilitation program for Iowans with chronic obstructive

lung disease.

New studies by researchers suggest high levels of serum cholesterol may contribute to abnormalities of platelets that may lead to transient ischemic attacks and strokes.

New strategies are emerging in the treatment of solid tumors. Autologous bone marrow transplantation following more aggressive chemotherapy is giving new hope to patients with breast cancer, testicular cancer or soft tissue sarcomas. The use of recombinant growth factors to stimulate bone marrow growth following toxic therapies shows great promise.

Increasingly, clinical data suggest medical intervention may prevent extreme osteoporosis and increased levels of heart disease following menopause. Estrogen replacement therapy may protect against rapid bone loss as well as slow the post-menopausal accelera-

tion of heart disease.

Early screening for colonic polyps using flexible sigmoidoscopy and colonoscopy gives hope of decreasing rates of colon cancer. Ongoing studies of the effects of vitamins C and E, beta carotenes, calcium and aspirin in reducing the rate of recurrence of polyps may one day reveal a useful strategy for prevention of colon cancer.

Based on measurements of human leukocyte antigen typing, insulin secretory capacity and blood antibody levels, it is now possible to predict development of type I diabetes before the onset of symptoms.

New technologies

A large population of people middle aged and older will benefit from application of biofeedback to the problems of constipation and fecal incontinence. While not itself a new technology, the use of biofeedback to treat these problems is still rare—Iowa is one of only a few centers to offer it.

Stress echocardiology, a new application of ultrasonography, has proven extremely sensitive for the detection of coronary disease.

Interferon alpha, an antiviral agent, will be used as a treatment for certain patients with chronic hepatitis.

The importance of parovirus infection in the clinical setting has been increasingly recognized in pediatric, hematologic, obstetric and rheumatologic patient populations.

Finally, to provide specialized support to physicians and patients in their home communities, the Department of Internal Medicine has initiated outreach consultation clinics. These clinics, established in cooperation with community physicians, will continue to expand in number and will offer community-based services in a number of internal medicine subspecialties.

Ophthalmology: vital and innovative

Thomas Weingeist, M.D., Ph.D.

Head, Department of Ophthalmology

STATE AND FEDERAL LAWMAKERS are expanding medical care by non-physician providers. Ophthalmologists and physicians of other specialties are affected, as the public accepts health care from a wide range of non-physician providers.

It is in the best public interest for physicians to lead the health care team. There is no more qualified physician to lead the team of vision care providers than ophthalmologists, who continue to be vital and innovative in a medical and surgical specialty that attracts some of the brightest medical students.

Next year, the National Eye Institute (NEI) will celebrate its 25th anniversary. Through all these years UI faculty and staff have been part of many of the clinical trials curported by the NEI.

supported by the NEI.

NEI-supported multicenter trials led to major clinical and surgical advances in the diagnosis and treatment of diabetic retinopathy, age-related macular degeneration, glaucoma, strabismus, optic neuritis, choroidal malignant melanoma myopia, and retinopathy of prematurity, to mention only a few. A summary of all 26 clinical trials funded in part by the NEI may be obtained free. (NIH Publication No. 90-2910, Clinical Trials Supported by the National Eye Institute.)

Cataract surgery

Nearly 1.5 million lens extractions were performed in America last year, making it one of the most common surgical procedures. Cataract surgery has undergone revolutionary change. It is performed most commonly under local anesthesia in an ambulatory surgical center. Visual rehabilitation is facilitated by microsurgical techniques and insertion of an intraocular lens placed in the posterior chamber following extracapsular removal of the crystalline lens. Placement of the intraocular lens has also reduced the incidence of aphakic cystoid macular edema and retinal detachment, potentially blinding consequences of cataract extraction. Most individuals experience marked visual improvement within a short time.

Glaucoma filtering operations and laser surgery

Treatment of chronic open-angle glaucoma is managed initially with topical beta-blockers such as timolol and betaxolol. When glaucomatous visual field loss continues despite medical management, laser trabeculoplasty with slitlamp delivery system is performed.

If maximum medical management fails, a glaucoma filtering procedure (trabeculectomy) is done. Multiple 5-Fluorouracil injections following surgery and more recently a single application of the anti-metabolite, mitomycin, appear to be effective in preventing closure of filtering blebs by fibroblastic proliferation.

Peripheral cryoablation

Retinopathy of prematurity (ROP) is a potentially blinding disease of infants weighing less than 1250 grams at birth. Trans-scleral cryotherapy of the peripheral retina has been effective in reducing the number of infants who become blind from ROP. The diode laser indirect ophthalmoscopic delivery system may prove to be even more beneficial. It can be administered more easily in the newborn intensive care unit, requires no anesthesia and can be delivered more accurately to the involved peripheral retina.

Diabetic retinopathy, age-related macular degeneration

UI Department of Ophthalmology members were instrumental in developing the first national clinical trials to evaluate laser photocoagulation for treatment of diabetic retinopathy and age-related macular degeneration. The major cause of blindness and visual disability in adults under age 60 is diabetic retinopathy.

The major cause of blindness in adults over the age of 60 is age-related macular degeneration, a disorder that could affect 6.3 million Americans by the year 2030. Fundus fluorescein angiography and laser surgery have been demonstrated to help many patients. Clinical trials designed to determine the efficacy of interferon to treat subfoveal neovascular members are under way. The utility of dietary supplements such as zinc and vitamins is unknown.

The efficacy of focal laser treatment of subretinal neovascular membranes arising in elderly patients with age-related macular degeneration, or in younger patients with the presumed ocular histoplasmosis syndrome (POHS) so prevalent in Iowa, has been demonstrated.

Laser photocoagulation of the peripheral retina in proliferative diabetic retinopathy and focal treatment for diabetic macular edema have also been shown to be useful.

Excimer laser surgery

Although excimer laser surgery has not gained FDA approval, it is the newest technological advance for the treatment of myopia. Computer and laser technology are being used to reshape the cornea without disturbing its clarity or damaging other ocular tissues. Researchers are struggling with refining ways to predict the final refractive error and maintain a stable correction.

Molecular basis of eye disease

Retinitis pigmentosa and Leber's optic atrophy, a mitochondrial dystrophy causing sudden and unexplained blindness in predominantly young men are the latest ocular diseases diagnosed using new techniques in molecular biology. Members of the Molecular Ophthalmology Laboratory at the University of Iowa can diagnose these and other conditions from a small sample of blood.

YUCO YOHIMBINE HO

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug. 1.2 Also dizziness, headache, skin flushing reported when used orally. 1,3

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence, 1.3.4 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.3

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC

53159-001-10 References

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PET scanning has promising future at UI Hospitals and Clinics

By the turn of the century, Positron Emission Tomography will be a major factor in better diagnosis and treatment in oncology, cardiology and neurology.

WITH A \$6.5 MILLION INVESTMENT in Positron Emission Tomography (PET), the University of Iowa Hospitals and Clinics has opened a new era in diagnosing disease.

By the turn of the century, PET's unique ability to determine metabolic function on a cellular level is expected to be a major factor in more precise, cost-effective diagnostic and therapeutic procedures in oncology, cardiol-

ogy and neurology.

Some cancer patients, for example, will have earlier diagnosis and staging. Because many tumors have higher metabolic rates than the healthy tissue around them, a PET image of the metabolic rates within a patient's body may detect tumors before conventional imaging techniques such as computed tomography and magnetic resonance.

"In the last two to three years, centers that have created images of the rate of glucose metabolism in patients with cancer have been able to show the location of the cancer," says Peter Kirchner, M.D., director of the division of nuclear medicine at the University of Iowa Hospitals and Clinics. "Of course, not all tumors are going to be found this way, but several different forms of cancer are likely to be staged by PET."

Because biochemical processes precede anatomical changes, establishing that a tumor is or is not metabolizing a selected biochemical material possibly will provide a more rapid method of evaluating the effectiveness of treatment. By assessing this effectiveness early, physicians will be able to more effectively determine the appropriate treatment plan.

"If several days after providing a sufficient amount of therapy, you could demonstrate that the tumor metabolism has dropped significantly, you would be able to predict with a great deal of assurance the tumor is responding to the therapy," Dr. Kirchner says.

A cancer patient and physician usually wait approximately three months to determine if a treatment has been effective. By indicating the presence or absence of tumor response more quickly, PET will reduce the amount of time wasted and allow exploration of treatment options before a cancer becomes unmanageable.

Researchers are also exploring the possibility PET can be used to monitor the toxic effects of chemotherapy on vital normal tissues such as bone marrow.

Cardiology and neurology specialists are also at the threshold of utilizing PET to enhance the diagnosis and treatment of patients.

In five to 10% of patients with coronary artery disease, physicians cannot determine

whether the portions of heart muscle that have greatly reduced blood flow are likely to recover after restoration of blood flow with angioplasty or surgical bypass. PET permits this assessment non-invasively.

"PET could be particularly useful in cases where a patient's heart muscle is failing," Dr. Kirchner says. "The surgical risk for these patients is high, but if you can demonstrate that portions of heart muscle are viable and capable of responding to revascularization, the risk becomes more reasonable because there is a chance of a good outcome."

PET has a number of possible applications in studies of the brain. PET may be used to localize the site where epileptic discharges begin. This information is very important when epilepsy cannot be controlled with drugs and surgery is being considered. Many disorders of brain function have no discernible anatomical abnormalities in their early stages, but biochemical and metabolic abnormalities may be present. PET can detect many such changes and will provide earlier diagnosis for a number of disorders that cannot be staged by CT or MRI.

Another application for PET may be in the management of stroke patients. Because areas within the brain are temporarily disabled during a stroke, monitoring the rate of recovery for these areas may become important for a patient's rehabilitation.

"The timing of rehabilitation could be addressed with PET. If you can define serially the metabolic potential of brain tissues during the recovery phase you could hope to define the point when you might be able to begin fruitful intervention and rehabilita-

tion," Dr. Kirchner says.
"When PET is effective as a diagnostic tool, it is likely to lead to much better assessment of the patient and the medical care is likely to be more cost effective," says Richard Hichwa, Ph.D., director of the PET center at the University of Iowa Hospitals and Clinics. "The investment in PET is expensive initially but if used to its fullest potential, PET is likely to reduce overall costs and result in better patient care."

These cost savings will be realized through quicker analysis and earlier discontinuance of ineffective treatments.



Senior technologist John Richmond injects a patient with a radiopharmaceutical and the PET scanner detects the spatial distribution of the radiopharmaceutical within a specified organ in three dimensions.

Dr. Kirchner says, "If the technology can be evaluated carefully so the application is done for specific applications where it is likely to help in important decision making, then there is a very real chance PET will save money or provide better results overall for a comparable cost. The important thing is not to take expensive technology and apply it indiscriminately in settings where it is not going to be helpful in making key decisions."

From a modest beginning approximately 20 years ago, PET has matured into a highly sophisticated technology. Dr. Hichwa says the entire process must become even more

automated.

"PET is automated, but each individual component has its own automation," he says. "If we can merge these individual systems, one person can sit at a computer terminal and run the cyclotron, the chemistry and the tomograph. This will release people from time consuming routine services to allow them to devote time to the cutting edge of research, which must be funnelled into clinical opportunities."

DIRECTOR, OBSTETRICS AND GYNECOLOGY Broadlawns Medical Center Des Moines, Iowa

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D.J. Walter, MD, Director of Medical Education, Broadlawns Medical Center, 18th & Hickman Road, Des Moines, Iowa 50314 515/282-2203.

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Questions and Answers



James Rohrer, Ph.D.

National health care planning: the shape of things to come

With national health care a tip-of-thetongue topic and a new basis for reimbursement just launched, IOWA MEDI-CINE asked the new head of the graduate program in Hospital and Health Administration in the University of lowa College of Medicine, to discuss likely results.

What do you expect from the RBRVS?

Resource-Based Relative Value Scale reimbursement is expected to cause income of primary-care physicians to rise relative to other specialties. Now the leading nation in medical specialists per capita, we may see less sub-specialization over the long term as physicians begin to recognize there may be less gain in earning potential for careers outside of primary care.

There are indications the rate of increase in physician income will drop, so that in constant dollars many incomes may already have peaked. We may return to the situation prior to World War II when the relative difference between physicians' and other salaries was less.

Will there be changes in the way physicians arrange their practices?

Efforts to reduce health service costs likely will further reduce the percentage of doctors in solo practice because incentives to enter HMOs and other forms of organized medicine will grow stronger. Insurers and buyers of medical coverage will continue to find ways to lower costs, creating pressures that will draw even more attention to issues of rationing and limiting the use of heroic measures to sustain life.

As physicians know, many policies have been tried in the name of cost containment, some more effective than others. It is likely peer review organizations, insurance companies and government will begin to move away from "micro-management" of physician decisions

and go to aggregate statistical analysis that will spot "blips" requiring a closer look.

We may also see decreasing faith in the malpractice system as a quality control mechanism and more control of quality through the same mechanisms that will control productivity of physicians. In other words, the "corporatization" of the physician and the development of managed care organizations will be directed at producing high quantity of output from minimum resources and a high value of services for the resources invested.

What about the autonomy of physicians?

Organized medical groups and staffs will have physician-leaders who will be responsible for quality-adjusted output through mechanisms that reduce the autonomy of the individual physician while retaining the autonomy of the profession. This autonomy will relate primarily to clinical decisions and how they affect the population being served rather than how they affect the individual physician.

The steady improvement in insurance coverage experienced almost since the Depression

has peaked and we are seeing a gradual "deinsuring" of the population. This almost certainly means the only long-term solution is a national health insurance program linked with some sort of change in incentives. Rationing will come into the picture, although so far we have been incapable of making overt rationing decisions.

Overall, do you expect a major rewriting of national health policy?

The odds seem to favor a general deterioration of the quality of insurance coverage with continuation of a patchwork system, but including a safety net for people completely without insurance and those who face costs far beyond coverages they can afford.

Health promotion and illness prevention programs will continue to have appeal and value but they will not reduce costs sufficiently to eliminate financial pressures on the health care system. People will continue to get hurt, get sick and ultimately die. Furthermore, longer life generates costs such as retirement benefits that are part of the total cost of being alive.

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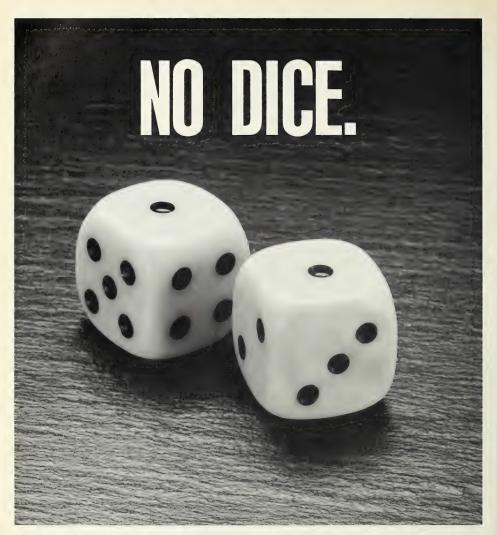
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Voiding dysfunction and incontinence

This is a progress report on the U. of I. Hospitals and Clinics Urodynamic Program, which offers lower urinary tract diagnosis and treatment and testing to define neurogenic causes. Case reports are included.

William Bonney, M.D.

Iowa City, Iowa

URODYNAMIC EVALUATION is a practical diagnostic study of lower urinary tract anatomy and function. Simultaneous measurement of volume, corrected bladder detrusor pressure, flow rate and sphincter activity provides data on leakage or voiding difficulty. Simultaneous video reveals bladder neck abnormalities and shows the level of any obstruction present. Measurements of sacral reflex activity and sphincter electromyogram (EMG) analysis can sometimes clarify otherwise obscure neurological disease.

Urodynamic study provides the most accurate basis for diagnosis and treatment of lower urinary tract malfunction. In some cases it also provides the needed treatment. With "biofeedback" training it is possible to learn bladder and urethral function again.

Between April, 1989 and December, 1991, 750 cases were completed in the Urodynamic Laboratory. Based in the Urology Department, U. of I. Hospitals and Clinics, the Urodynamic Program is a resource for physicians and surgeons in all specialties.

Services offered

The Voiding Dysfunction Clinic offers comprehensive diagnosis and surgical or medical management for patients of all ages, either sex. Problems include incontinence, voiding difficulty, obstruction, neurogenic bladder and lower urinary tract damage from surgery or radiation.

New patients complete a questionnaire and measure voided volumes at home. The first visit is then devoted to interview, physical examination, urinalysis and culture, renal function and selected tests as needed (e.g., cystoscopy, voiding X-rays and IVP or renal ultrasound).

Follow-up clinic visits provide interpretation of test results and treatment recommendations, therapeutic procedures, instructions for self-care and evaluation of treatment results.

The Urodynamic Laboratory serves patients from the Voiding Dysfunction Clinic and those referred for urodynamic study alone. Specific tests include:

• Noninvasive uroflow (before any urethral instrumentation)

The author is associate professor and director of the Urodynamic Laboratory, Urology Department, University of Iowa Hospitals and Clinics, Iowa City.

THE IOWA MEDICAL FOUNDATION HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC
PRESENTATION AWARD FOR APRIL 1992

• Cystometry (test of urine storage), supine, upright or ambulatory with corrected detrusor pressure

Voiding study with corrected detrusor

pressure and sphincter EMG

Static urethral pressure profile

Dynamic urethral pressure recordings

Stimulated evoked sacral responses
 Urethral and anal sphingtor FMC ways

 Urethral and anal sphincter EMG waveform analysis

• Biofeedback sphincter training in laboratory setting and home.

Recent cases

Problem: Before surgery for female stress incontinence, a formal urodynamic study is often needed to exclude detrusor instability and urge incontinence—causes of persistent leakage that can be difficult to control after surgery.

Case 1. This woman in her late 50s had daytime stress incontinence since the last of 4 vaginal deliveries. She voided 7 times a day with urgency and a good stream. On urodynamic study she had normal bladder capacity and genuine stress incontinence—leakage with cough in the absence of bladder muscle contraction (Figure 1). She experienced no urge

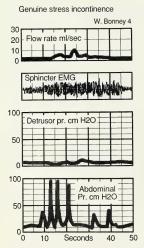
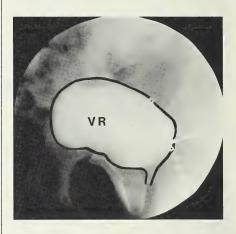
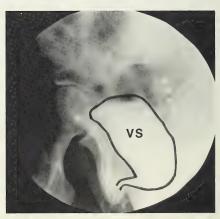


Figure 1. Urodynamic study, female. Test of urine storage at 685 ml bladder volume, showing genuine stress incontinence without any urge incontinence. She leaked 110 ml with abdominal strain despite good sphincter contraction.

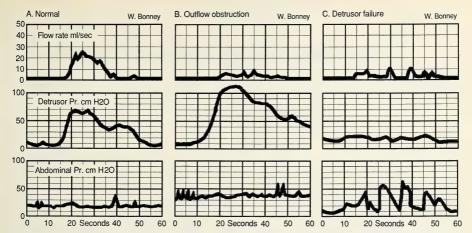
incontinence. Urethrocele was seen on X-ray and cystoscopy (Figure 2). After PR3 urethral suspension (a vaginal operation to correct stress incontinence) she was free from all leakage, still voided with a good stream and needed no medication.

Problem: In men with prostatic enlargement and slow stream, a formal urodynamic study is the only reliable way to distinguish between obstruction, which needs TUR of the





Figures 2a and 2b. Voiding cystourethrogram, woman with urethrocele. (a) VR, Void relaxed. (b) VS, Void with abdominal strain. For lack of support, bladder and urethra descend behind pubis and bulge into vagina.



Figures 3a, 3b and 3c. Urodynamic study, voiding tests in men. (a) Normal void by smooth bladder muscle contraction and rapid flow. (b) Outflow obstruction with high pressure bladder muscle contraction and slow flow. (c) Bladder muscle failure, void by abdominal strain with interrupted flow.

prostate, vs. bladder muscle failure, which needs intermittent catheterization (not surgery).

Case 2. A patient in his 80s had a hesitant, interrupted stream and sometimes voided with abdominal strain. On urodynamic study the voiding test showed obstruction with a high pressure, sustained bladder muscle contraction and low flow rate (Figure 3). After TUR of the prostate he voided to completion with a rapid, steady stream.

Čase 3. A patient in his 70s had a hesitant, interrupted stream and voided with abdominal strain. A previous TUR had brought no lasting improvement and repeat surgery was under consideration. Urodynamic study showed failure of bladder muscle contraction and no obstruction (Figure 3). He could void only by abdominal strain with high residual urine volume. He subsequently did well on intermitent self catheterization. There was no indication for surgery, and perhaps never had been.

Prospective clinical investigations

Current problems under study include the following:

1. Surgical management of stress incontinence in women, with special attention to those who also have voiding dysfunction and might void poorly after surgery.

- Study of neurological status in patients with detrusor instability (urgency and urge incontinence) of unknown cause.
- 3. Innovative treatments for detrusor instability (urgency and urge incontinence) which is "refractory" to usual therapy.
- 4. Pharmacologic treatment of bladder dysfunction with objective measurement of results.
- 5. Specific technical improvements in the urodynamic study.
- 6. Analysis and quantification of voiding X-ray results in comparison to female stress incontinence and its surgical correction.
- 7. Safe, cost-effective ways to image the urinary tract during urodynamic study.

Future prospects

The goal of the Urodynamic Program is to improve service to patients and referring physicians and become a source of new ideas. At this writing the Urodynamic Laboratory is staffed and operational at 40% of projected capacity. Renovation of dedicated laboratory space in the near future will streamline each patient's evaluation and hopefully reduce waiting time by a natural process of staff expansion. Urodynamic reports are under revision to convey both quantitative data and easily understood interpretation of results.

Mercy Hospital Medical Center Des Moines, Iowa Presents

"Mercy Heart Days '92" May 6-7, 1992

Guest Faculty

William C. Cushman, M.D.

Practical Report on the VA Cooperative Study on Hypertension Monotherapy Study

Associate Professor of Medicine and Preventive Medicine.

University of Tennessee College of Medicine Chief, Hypertension Section, Veterans Affairs Medical Center

Memphis, Tennessee

John Eric Deanfield, M.D.

Treatment of the Outpatient with Stable Angina Senior Lecturer Institute of Child Health University of London London, England

Joseph R. Hartmann, M.D.

New Devices and Technology in Interventional Cardiology Medical Director, Midwest Cardiovascular Institute, Associate Clinical Professor of Medicine, Loyola University Medical Center Chicago, Illinois

Host Faculty

L.A. Iannone, M.D.
Thomas M. Brown, M.D.
William J. Wickemeyer, M.D.
R. R. Rough, M.D.
Magdi G. H. Ghali, M.D.
W. Ben Johnson, M.D.
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Jeffrey J. Boyd, M.D.
Galen G. Van Wyhe, M.D.
Steven J. Bailin, M.D.
S. V. Advani, M.D., Ph.D.
Thomas B. Edel, M.D.
Cindy Conroy, R.D., L.D., M.A.

Concurrent sessions on cardiac-related areas of interest will be faciliated by the physicians and registered dietitians of the Iowa Heart Center.

Mercy Heart Days '92 will incorporate a dual focus. Both invasive and non-invasive approaches to the treatment of heart disease and cardiovascular complications will be addressed. This year's symposium replaces Mercy Heart Day and the Mercy Interventional Cardiology Conference, previously presented annually as separate and distinct programs.

Approved by Mercy Hospital Medical Center, an IMSaccredited CME organization for 12 hours of Category I AMA

Physician Recognition Award.

Category I (May 6: 6 hours; May 7: 6 hours)

Nursing CEUs: 0.7 (7 contact hours)

May 6 (0.7) and May 7 (0.7) (Total 1.4, 14 contact hours)

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The seminar will be held at the Mercy Education Center,
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Contact: Department of Medical Education Mercy Hospital Medical Center Sixth and University Des Moines, Iowa 50314 • Ph. (515) 247-3042



Taking charge of our CME

Richard Nelson, M.D.

Towa Physicians Must document their CME activity when applying for relicensure. Physicians meet this requirement through myriad educational experiences largely determined by personal preference. It is widely anticipated that the majority of medical and surgical specialties will require periodic recertification in the future. Some states (notably California and Florida) require a cognitive examination of mid-career physicians seeking licensure.

Most physicians construct their continuing education experiences without a rigorous plan. We attend lectures or courses that offer content of interest. We subscribe to audiotape series that concentrate expertise into digestible segments. We read journals, magazines and newsletters with whatever thought and

persistence our schedules permit.

In sum, these experiences often condemn us to passive learning. We learn, but not necessarily with deliberate attention to improving our functional competence as physicians or enhancing our understanding of the rapid evolution of health care delivery and its effects.

We have the ability to structure our personal CME. While there is no single strategy that will be helpful to all physicians, the fol-

lowing process may be useful.

1. Take stock. List all CME experiences for which you have received Category 1 credit during the past four years (or two relicensure periods). Draw a line through those events or activities that, in retrospect, have been of limited

value to your educational needs. Consider why the others have been of value.

- 2. Develop a plan. While the value of recent CME activities is fresh in mind, list five issues or topical areas about which you need to learn during the next two years. Keep or post that list in a place that you periodically reference.
- 3. Structure your education. Seek out courses, lectures and materials that address your goals. This may be done with relative ease by accumulating a file of courses and events offered by specialty societies, academic medical centers and community hospitals or medical societies.

This deliberate effort will assist you in taking charge of your own education. Many options exist for shaping your experience. The U. of I. College of Medicine, for example, offers individualized traineeships for practitioners in addition to numerous courses and special educational events throughout each year. Our Office of CME can help arrange an educational experience tailored to your needs for one or more days with departmental faculty. Each full day of this continuing education activity is designated for seven credit hours. There is a registration fee.

Physicians pursuing the Physician's Recognition Award of the AMA also have the opportunity to structure CME activities, including participating in teaching, publication and self-directed reading for Category 2 credit. There may be a requirement for Category 2 credit after January 1, 1993.

The public's demand for professional accountability may well lead to stricter future licensure and relicensure criteria. Such criteria need not intimidate the motivated physi-

cian learner.

Dr. Nelson is associate dean for continuing medical education at the University of Iowa College of Medicine.

Peer review: a learning proposition

PEER REVIEW, A FACET OF QUALITY patient care, benefits from participation by practicing physicians who become involved and apply their medical/clinical expertise to the review of medical records. Peer review ensures that physicians' care plans are reviewed by practicing physicians in Iowa. It's an educational process with far-reaching effects.

Peer review has been required for 20 years and will be around for many more. And we have to concede, even if we don't like the review process, there's comfort in knowing a physician with hands-on experience is reviewing our patient care.

Opportunity to learn

Peer reviewer decisions affect patients, their families, physicians, hospitals and others. Therefore, to understand accepted treatment plans and their anticipated outcomes, peer reviewers must remain well-informed about medical therapies and their expected outcomes. The review process helps peer reviewers constantly sharpen their skills as physicians. Peer review is a great opportunity to learn for those involved. In fact, you can't avoid learning.

The role of the physician reviewer is changing. Because of the current state of health care in the U.S., new projects and studies are constantly evolving and being undertaken by the Health Care Financing Administration (HCFA) and state departments of health to control health care costs and provide for quality patient care. Many of these projects and studies

ask for input from physician reviewers. Why? Because physician reviewers are in the unique position of both providing and reviewing patient care. They are on the front line in the

'The present system of review isn't perfect. As a physician, you have a voice in the present and future direction of peer review.'

current health care system and are committed to making the health care system work more efficiently for everyone.

System isn't perfect

Certainly, the present system of review isn't perfect, but it isn't static either. It's changing to accommodate technological advancement and provide for a national data base that will benefit all of us. As a physician reviewer, you have a voice in the present and future direction of peer review. You have an opportunity to see that changes with which you've had input are implemented. On a local level, you have the opportunity to participate in peer review on a daily basis, thus impacting Iowans and Iowa health care concerns.

I urge Iowa physicians to take an active role in this important educational review process. It will benefit you and it will benefit your peers. Please write or call the IFMC to express your interest in becoming a physician reviewer.

This article was written by Don Green, M.D., a family physician in Des Moines. He has been an IFMC reviewer for three years.

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Sexually active teens

I OWA'S TEEN BIRTH RATE CONTINUES to be high even though the teen population is declining. This disturbing trend has prompted the IDPH to expand its family planning services in an effort to address teenage sexuality and reduce unplanned pregnancies in Iowa.

As many as two-thirds of all adolescents in the U.S. are sexually active, according to some studies. Teens are at risk for unplanned pregnancies resulting in low birthweight and premature babies, high infant mortality, unhealthy babies, HIV/AIDS and other sexually transmitted diseases (STDs), as well as other health,

economic and social problems.

Sexually active adolescents delay their initial visit to a health care facility for reliable contraception an average of one year from the time of their first intercourse, according to national study described in the *Journal of Adolescent Health* 1991 (Vol. 12, No. 3, pp. 225-32). Procrastination is one of the most frequently cited reasons for not seeking birth control. This one-year delay with no reliable method of birth control results in a 60-80% chance of pregnancy.

The IDPH is marketing the following message to sexually active individuals:

If you have had intercourse even once, you are at risk of pregnancy, a sexually transmitted disease (STD), or HIV/AIDS—risks which could affect you for the rest of your life. The time to think about protecting yourself is BEFORE you consider having intercourse. If you put it off until later, it may be too late. Find out more about family planning and STDs NOW. If you don't know of a family planning health clinic, call toll-free 1-800-369-2229 for confidential information and referral to a family planning clinic near you.

The IDPH, along with the Family Planning Council of Iowa, sponsors and supports publicly-funded (Title X) family planning agencies throughout the state. These clinics offer confidential medical and counseling services and individual and community education about reproductive health issues. Medical services at these clinics are directed by physicians trained in family planning. Health care and counseling programs also are provided by trained staff. Educational programs are designed to respond to local community needs.

All services at a public Title X family planning clinic are available to Iowa residents regardless of religion, race, color, age, sex, number of pregnancies or marital status. Clinic fees are based on the client's ability to pay, with no charge for services to people enrolled in Medicaid or whose income is below the federal poverty guidelines.

Local Title X Family Planning Centers offer Iowa residents the following services:

Medical services for birth control exams and supplies; tests and treatment for sexually transmitted diseases; Pap smears and breast exams; infertility exams, counseling, and referral; sterilization services; screening for high blood pressure and anemia; and pregnancy tests when needed to make appropriate referrals for pregnancy counseling and prenatal health care.

Health education on reproductive health; all methods of birth control; self exams for breast or testicle cancer; sexually transmitted diseases; the importance of nutrition; the effects of alcohol, drugs, and tobacco on reproductive health; preconception health; and the need to prevent unplanned pregnancies.

Counseling on reproductive health; preconception health; communication with parents and others about sexuality; and sexuality

and responsible decision making.

Community education on parent-child communication, reproductive health, birth control, and other family planning issues. Public speakers, printed materials and videos are available.

This material is furnished by the Iowa Department of Public Health.

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The changes in health care and health coverage in the last five decades have been tremendous. And, through it all, Blue Cross and Blue Shield of Iowa has helped set the pace.

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College of Medicine Highlights

A NEW LONG-TERM RURAL HEALTH STUDY conducted by U. of I. College of Medicine researchers will focus on Keokuk County residents. The Keokuk County Rural Health Study will examine the relationship between common rural environmental exposures and respiratory disease, injuries and other health factors. The only rural health study of its kind, the Keokuk study is modeled after the famous Framingham heart study, which has examined the cardiovascular health of residents in the Massachusetts town for more than 40 years. Dr. James Merchant, director of the UI Institute of Agricultural Medicine and Occupational Health, will direct the project.

THE CENTER FOR THE STUDY OF OLDER RURAL POPULATIONS is being established at the UI with a three-year, \$900,000 grant from the National Institutes of Health. The center, one of four in the country, is directed by Dr. Robert Wallace, preventive medicine and environmental health. Topics to be studied through the center include pesticide use among older agricultural workers, availability of health care in rural towns and other social demography issues, and diseases of historically understudied populations.

FIVE TO 10% OF U.S. HOSPITAL PATIENTS acquire an infection while in the hospital, says Dr. Richard Wenzel, internal medicine. Wenzel has received a \$400,000 grant from the National Institutes of Health for a five-year program to train physicians about techniques useful in controlling and preventing infections in hospitals. The program will provide postgraduate training for doctors already trained in internal medicine and infectious diseases.

UI NEUROLOGY RESEARCHERS, LED BY DR. ANTONIO DAMASIO, continue their research on the human brain with a \$5.2 million grant from the National Institutes of Health. They will use newly developed techniques for producing three-dimensional maps of the brain to study how the brain is organized to handle language and cognition. Other neurology researchers involved in the study include Drs. Hanna Damasio, Daniel Tranel, Gary Van Hoesen, Kathy Rockland and Matthew Rizzo.

DR. JEAN ROBILLARD, PEDIATRICS, was awarded a \$3 million grant from the National Institutes of Health for a five-year study of how the kidneys and urinary tract develop during fetal and postnatal life. The grant will fund the establishment of a Center for Excellence in Pediatric Nephrology and Urology at the UI.

THE EFFECT OF COCAINE ON THE DEVELOPING BRAIN is the focus of a study by Dr. James West, anatomy. The National Institute on Drug Abuse awarded West \$550,000 to study changes in the brain that result from cocaine exposure. West and Dr. Charles Goodlett, anatomy, will look at the effects of exposure during the period of most rapid brain growth, equivalent to the human third trimester. "While cocaine and crack babies are a great concern, little is known about the way cocaine actually affects the brain," West says.

DR. RICHARD JENKINS, professor emeritus of child psychiatry, died December 30 at the age of 88. From 1961 to 1971, Jenkins was professor and head of the child psychiatry division of the UI Department of Psychiatry. Jenkins received national and international recognition for his work in describing and classifying conduct disorders in child psychiatry, particularly juvenile delinquency.

(Continued next page)

CHRONIC USE OF MARIJUANA shows no significant effect on reproductive hormone concentrations in either men or women, reports Dr. Robert Block, anesthesia. Results of Block's study, published in Drug and Alcohol Dependence, differ from a widely publicized report that appeared in the New England Journal of Medicine in 1974. The earlier results showed that chronic use of marijuana by men decreased testosterone levels.

SOME SPORTS DRINKS ARE BETTER THAN WATER for replacing body fluids lost during exercise, reports Dr. Carl Gisolfi, physiology and biophysics and exercise science. Gisolfi's study, published in the December 1991 issue of the *Journal of Applied Physiology*, found that these sports drinks can replenish fluids more quickly and provide energy but do not harm other bodily functions. The study was funded by a research grant from the Gatorade Sports Science Institute.[®]

PRE-EMPLOYMENT DRUG SCREENING **PROGRAMS** are not cost-effective for all companies, reports Dr. Craig Zwerling, preventive medicine and environmental health, in the January 1 issue of JAMA. Zwerling and researchers from Tufts University and Harvard University analyzed a screening program of the U.S. Postal Service in Boston and found pre-employment drug screening would save the Postal Service about \$162 per worker for the first year through reduced absenteeism and lower rates of accidents, injuries and employee turnover. But the authors caution certain factors can negate the savings associated with screening. "For example, in Boston, 12% of postal applicants tested positive for drugs. In Iowa, I would expect less than one-third as many positives. So an Iowa company might well lose money by drug testing," Zwerling says.

HONORS: Dr. Francois Abboud, internal medicine, received an honorary doctor's degree from the University of Lyon in France. Abboud was honored October 30 during the 7th International Symposium on Genetic Hypertension.... Dr. C. Patrick Burns, internal medicine, was appointed to the American Board of Internal Medicine's Subspecialty Board on Hematology (ABIM). As a member of the board, Burns will help establish training and certification requirements for physicians specializing in hematology.... Dr. Thomas

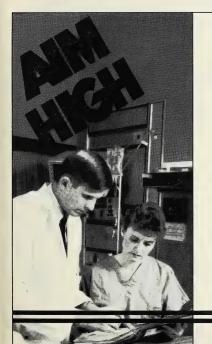
Kent, pathology, received the 1991 Distinguished Service Award in Academic Pathology from the Association of Pathology Chairmen. The award recognizes Kent's contributions to teaching and developing instructional materials, particularly his leadership in founding and developing the Group for Research in Pathology Education. . . . Dr. Paul Seebohm, professor emeritus and consultant to the dean, received the Distinguished Achievement Award from the UI Department of Internal Medicine. Seebohm was honored for his contributions to medical care and education at the Progress in Internal Medicine Conference October 17. Seebohm has served as president of the Iowa Medical Society, the State Board of Health and the American Academy of Allergy and Immunology.... Dr. Richard S. Tyler, otolaryngologyhead and neck surgery, was the guest of honor at the Japanese Audiological Society meeting in Japan in November. Tyler gave a lecture titled "A Comparison of Cochlear Implants Around the World."

PLAYING TAPE-RECORDED SUGGES-TIONS DURING SURGERY is not likely to fast-forward the patient's postoperative recovery period, reports Dr. Robert Block, anesthesia. More than 200 patients participated in the study. For half of the patients, recorded messages suggesting a smooth and rapid recovery were played during surgery. Following surgery, the patients' pain, need for pain-killing drugs and length of hospital stay were recorded. No meaningful benefits were found to result from the recorded messages. The study was published in the November 1991 issue of Anesthesiology.

NEW BOOKS: Laser Surgery in Ophthalmology: Practical Applications, published by Appleton and Lange, was edited by Dr. Thomas A. Weingeist, ophthalmology, and Dr. Scott R. Sneed, a former UI vitreoretinal fellow. Other UI contributors include Drs. Wallace Alward, Christopher Blodi, James Folk, Karen Joos, Alan Kimura, Hansjoerg Kolder and Jose Pulido, all of ophthalmology... Dr. Richard Wenzel, internal medicine, edited Assessing Quality Health Care: Perspectives for Clinicians. The text, published by Williams and Wilkins, is the first to address clinical, epidemiological and quality assurance issues from the perspective of the practitioner, Wenzel says.

IMS Auxiliary Annual Meeting-Marriott Hotel, Des Moines, Mrs. Martha Holzworth, Presiding

Saturday, April 25 Friday, April 24 8 A.M. REGISTRATION-Third Floor Fover 7:30 A M PAST PRESIDENTS' BREAKFAST BOARD OF DIRECTORS MEETING 8 A.M. REGISTRATION-Third Floor Fover 9 A.M. Exhibits Open COFFEE & MUFFINS OPENING OF 63RD ANNUAL MEETING Hostesses-District Councilors 10 A.M. Election of 1992-93 Officers and Nominating 9 A.M. HOUSE OF DELEGATES Election of 1992 AMAA Convention Delegates "40-Year" IMSA Member Recognition Presentation of Volunteer Health Service Keynote Address-Mrs. Priscilla Gerber, AMAA Reports of District Councilors, County Reports of District Councilors/County Presidents and Committees Presidents NOON RECEPTION FOR MRS. MARY FOLEY. Memorial Service LUNCHEON HONORING COUNTY 1992-93 STATE PRESIDENT NOON 12:30 P.M. LUNCHEON PRESIDENTS & PRESIDENTS-ELECT Honoring Mrs. Priscilla Gerber, National County Gift Exchange Drawing Guest, Past State Presidents and Special SEMINAR-Mrs. Mary Foley, Presiding "Crash of United Flight 232-The Sioux City Response' Presentation of "Auxilian of the Year" Award Installation of Officers-Mrs. Priscilla Gerber. Don Boyle, M.D., Sioux City AMAA 2 P.M. BOARD ORIENTATION County Presidents, Presidents-elect, Officers Presentation of President's Pin and Gavel Inaugural Remarks-Mrs. Mary Foley and District Councilors Presentation of Past President's Pin SOCIAL HOUR & DINNER 6:30 P.M. Home of Dr. Robert & Loretta Sieman 2:30 P.M. Consultations with Priscilla Gerber, AMAA



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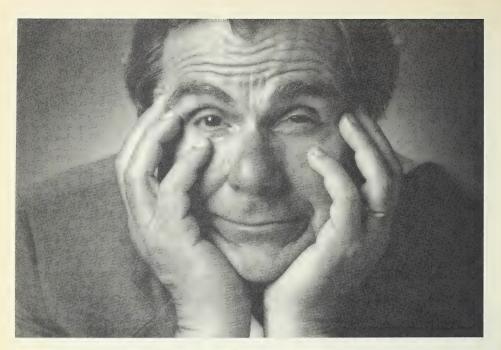
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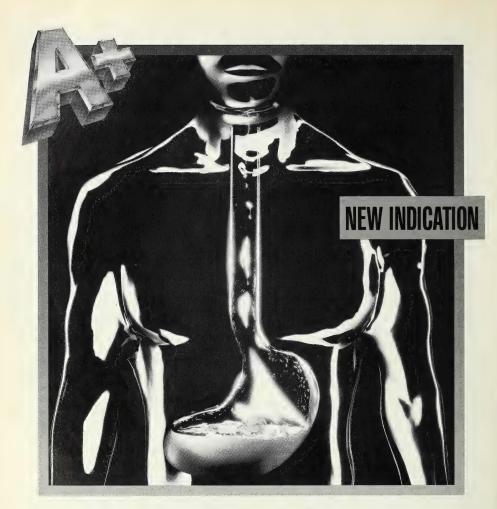
About Iowa Physicians

Items in this column are compiled from newspaper clippings from the Iowa Press Clipping Bureau. News from individual physicians, clinics and hospitals is welcomed and encouraged.

Dr. Luis Barrios has begun practice in Oxford. Dr. Barrios formerly practiced in Vinton. Dr. Sawat Phruttitum has begun practice with Drs. Clarkson Kelly, Val Lyons and William Spencer in Charles City. Dr. Phruttitum received the M.D. degree from Faculty of Medicine at Chiengmai Hospital University of Medical Sciences, Chiengmai, Thailand. He completed an internship at St. Francis Hospital, Evanston, Illinois and most recently practiced medicine at Union County Hospital, Anna, Illinois. The following physicians were recently elected officers of the medical staff at North Iowa Medical Center: Dr. Phillip Lee, president; Dr. Adrian Wolbrink, president-elect; and Dr. Bradley Isaak, secretary/treasurer. Dr. Prasad Mikkilineni has begun practice in Keokuk. Dr. Mikkilineni received the M.D. degree from Guntur Medical College, Guntur, India and completed residencies in Independence, Iowa and Winnebago, Wisconsin. Dr. Mikkilineni previously practiced in Green Bay, Wisconsin. Dr. Gary **Richardson** has begun medical practice in Newton. Dr. Richardson previously practiced in Charles City for 16 years. Dr. Janusz Bardach, U. of I. College of Medicine professor emeritus of plastic surgery, recently received a medallion of honor from the International Society of Plastic Surgeons at an awards ceremony in Germany. Dr. Stephen Noel has

joined Northwest Iowa Orthopaedics, P.C., Sioux City. Dr. Noel received the M.D. degree from the U. of I. College of Medicine and served a residency at the University of Wisconsin, Madison, Wisconsin. Dr. John Paschen, Ames, was recently elected to fellowship in the American Academy of Pediatrics. Two physicians have begun practice in Spencer: Dr. Tara Myerly Hata and Dr. Steve Hata. Dr. Tara Myerly Hata received the M.D. degree from the U. of I. College of Medicine and completed an anesthesiology residency at U. of I. Hospitals and Clinics. Dr. Steve Hata received the M.D. degree from the University of Missouri School of Medicine, Columbia, Missouri and served an internal medicine residency at U. of I. Hospitals and Clinics. The following physicians have been elected to the St. Luke's Hospital medical staff in Cedar Rapids: Dr. Arthur Devine, president; Dr. Larry Helvey, president-elect; and Dr. James LaMorgese, secretary/treasurer. Dr. Christopher White, Norwalk, was recently appointed chief medical examiner for Warren County. Dr. John Van Metre and Dr. Kenneth Killian have joined the Keokuk Clinic. Dr. Van Metre received the M.D. degree from the U. of I. College of Medicine and completed a residency at the University of North Dakota, Fargo, North Dakota. Dr. Killian received the M.D.

(Continued on page 189)



ONLY ONE H-ANTAGONIST HEALS REFLUX ESOPHAGITIS AT DUODENAL ULCER DOSAGE. ONLY ONE.

Of all the H_2 -receptor antagonists, only Axid heals and relieves reflux esophagitis at its standard duodenal ulcer dosage. Axid, **150** mg b.i.d., relieves heartburn in **86%** of patients after one day and **93%** after one week.

AXID nizatidine 150 mg b.i.d.

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nizatidine capsules

Brief Summary. Consult the package insert for complete prescribing information.

complete prescribing mitorination.

Indications and Usage: 1. Active duodenal uicer—
for up to 8 weeks of treatment at a dosage of 300 mg
hs. or 150 mg bul. Most galents heal within 4 weeks.

2. Maintenance therapy—for healed duodenal uicer
patients at a dosage of 150 mg hs. at betelinr. The
consequences of therapy with Axid for longer than 1
wear are not known.

consequences or metary with load of the period of the peri Contraindication: Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H₂-receptor antagonists, including Avid, should not be administered to patients with a history of hypersensitivity to other H₂-receptor antagonists.



Precautions: General-1. Symptomatic response to nizatidine therapy does not preclude the pr

gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Too ting tools, was definitiseness concurrency.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A 2-year oral carcinogenicity study in rats with doses as high as 500 m/gkg/day (about low lines be recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromatfin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as companed with placebo. Female mice given the high dose of Axid (2,000 mg/kg/dx, about 300 limes the human dose) showed placebo. Fernilae rince given the high dose of Axial (2,000 mg/hg/day, about 330 times the human dose) showed manginally statistically significant increases in hepatic common and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-day of the hepatic control increase seen has any of the other dose groups. The rate of hepatic carcinoma in the high-animals was within the hebrorical control limits seen for the strain of mice used. The fernilae mice were used and larger than the maximum blemted dose, as indicated by excessive (30%) weigh decrement as compared with concurrent controls and evidence of mild liver limity. (Instantinable evidence) he occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatidoxic dose, with no evidence of a concuraging effect in rats, male mice, and fernilae mice (given up to 500 mg/hg/dg/s, about 50 times the human dose, and a negative mitugenicip battery are not considered evidence of a corcingenic potential for Acid bacterial mutation losts, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay chromosome abertation tests, and a microrrucleus test.

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by treated addating rais, a decision should be made whether to discontinue fursing or the drug, taking into account the importance of the drug to the mother. Pediatric User—Salety and effectiveness in children have not been established by the soft of the Carbon Salety and effectiveness in children have not been established. But younger age groups as were the raise of adverse events and laboratory lest advicemables. Age allower may not be an important factor in the disposition of inzatidatic Effects patients may have reduced renal function.

lactor in the disposition's wind and particular the disposition of the

between Axid and placebo in the incidence of any of these events (see package insert for compilere information). A variety of less common events were also reported, it was not possible to determine whether these were caused by inizabidina:

We consider the common events of the common events and events of up to 3 times the upper limit of normal, however, did not applicately and in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, a placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, a placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, a placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, a placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, a placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, and the common event of the common events of the

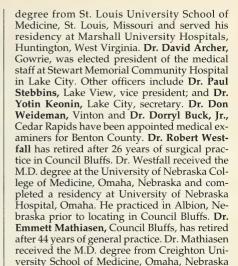
Overflosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal emissis, or lavage should be considered along with clinical monotrioning and supportive therapy. The ability of themodallysis to remove nazafidine from the body has not been conclusively demonstrated, however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this meth

Additional information available to the profession on request



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Deaths

Dr. Sylvan Lehr, 80, Cedar Rapids, died January 17 at St. Luke's Hospital in Cedar Rapids. Dr. Lehr received the M.D. degree at Northwestern University Medical School, Chicago, Illinois and practiced in Cedar Rapids for 35 years, retiring in 1981.

and completed an internship at Mercy Hospital

Medical Center, Des Moines.

Dr. Roman Fisch, 84, Le Mars, died February 1 at Plymouth Manor Care Center in Le Mars. Dr. Fisch received the M.D. degree from Creighton University School of Medicine, Omaha, Nebraska and served internships at Creighton Memorial St. Joseph Hospital and Douglas County Hospital, both in Omaha, Nebraska. Dr. Fisch practiced in Le Mars for nearly 40 years, retiring in 1976.

Dr. Charles Coughlan, 86, Fort Dodge, died January 15. Dr. Coughlan received the M.D. degree from the U. of I. College of Medicine and interned at U. of I. Hospitals and Clinics. Dr. Coughlan practiced in Fort Dodge for nearly 35 years, retiring in 1976. He was a life member of the Iowa Medical Society.



PV 2093 AMP

April 1992

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DISEASES AND SURGERY OF THE COLON AND RECTUM

Research increasingly aimed at prevention

Editors' note: This month's guest columnist is Professor Rex Montgomery, Ph.D., D.Sc., associate dean for Academic Affairs, U. of I. College of Medicine, and member of the Wallace Technology Transfer Foundation board of directors.

It is more advantageous to maintain a house in good condition than to repair the problems of wood rot. By the same token, it is wiser to maintain one's health than to treat a preventable disease, whereby the quality of life is improved.

Increasingly, research efforts of scholars in the health sciences are being directed towards the prevention of disease. This has become possible with basic scientific research on the etiology of disease, the molecular biology of cellular and organ processes and genetic controls. With the beginnings of these foundations of biomedical science firmly in place, it is gratifying to see new faculty members in the U. of I. College of Medicine researching methods of prevention as well as palliation, and to find more senior faculty learning the ways of the new biology.

Correcting "bad" genes?

Much discussion these days centers on the investment of resources necessary to detail the structure of the human genome, which determines much of the structure and function of the adult person and contributes to the viability and health of the offspring.

From a knowledge of all the genes and gene products, an individual's risk for disease may be predictable. For example, people who carry the ATHS gene appear to have an increased susceptibility to develop atherosclerosis. Genetic engineering may not yet be to the point of correcting "bad" genes, but with appropriate probes and technology to point to a predisposition for disease, palliation or correction of the effects can be undertaken. Examples could be the avoidance of galactose by the galactosemic baby or the correction of iron overload by phlebotomy before serious, irrevocable damage occurs.

Parallel advances have occurred in immunology, where the defensive responses of the body are now more clearly understood at a molecular level. With the development of monoclonal antibodies that are specifically directed to a single structural component of an antigen, it is possible to detect abnormalities in proteins and detect disease at an early stage. With monoclonal antibodies one can quantitate drugs in the blood with office test kits, titrating dosages that are effective but not toxic.

More is on the way

A final example of improvement in health care that results from basic and applied research is the search for materials that can be inserted in the body. Orthopaedic prostheses have significantly improved the life-style and comfort of many patients. Improvements in cochlear implants, pacemakers, *in vivo* sensors, and implanted delivery systems to dose insulin and other drugs may prevent late-stage development of the consequences of disease.

This much we have on hand. More is on the way. The question now remains: Is the health care system prepared to handle these successes of basic science?



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†Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

*Verapamil should be administered cautiously to patients with impaired renal function

BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see Warnings), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3nd-degree AV block (if no pacemaker is present), attil flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

bypass tract (eg. WPW or LGL syndromes), hypersensitivity to verapemil Whernings: Venapmil should be avoided in patients with severe Ut dysfunction (eg. ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with avere degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver entrymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic tarial fuller/fibrillation and an accessory Apt pathway (eg. WWW or LGL syndromes) have developed in increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventroider fibrillation after receiving I.V. verapamil for digitalisj. Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and cod-degree, 0.8%). Development of marked 1st-degree block or progression to Znd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, risus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil. treated with verapamil.

treated with verapamil. Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchemés muscular dystrophy and may prolong recovery from the neuromuscular blocking gent veuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmis-sion. Combined therapy with beta-adrenergic blockers and verapamil may result in additive sion. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atmoventroular conduction and/or cardiac contractility, there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolo and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitals toxicity, in patients with hepatic circhosis, verapamil may reduce total body clearance and extraereal clearance of dictions. The diloquin force should be reduced when verapamil is owing and the natient carefulis. digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully



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References: 1. Data on file, Searle. 2. Edmonds D, Würth JP, Baumgart P, et al. References: 1. Data on file, Searle. 2. Edmonds D, Wirth JP, Baumgart P, et al. Twenty-four-hour monitoring of blood pressure during calculum antagonist therapy, In: Fleckenstein A, Laragh SH, eds. Hypertension—the Next Decade: Verapamil In Focus. New York, W: Churchill Livingstone; 1987-94-100. 3. Middto KA. Effects of long-term verapamil therapy on serum lipids and other metabolic KA. Effects of long-term verapamil therapy on serum lipids and other metabolic parameters. Am J Cardiol. 1990;66:131-151. A Fagpier B, Henningsen N, Hulthén L, et al. Antihypertension. Eur J Clin Pharmacol. 1990;391suppl 11:541-543. 5. Schmieder RE, Messeri FH, Caravagila CE, et al. Cardiovascular effects of verapamil in patients with essential hypertension. Circulation. 1987;75:1030- 1031. B Midtob K, Luw O, Hals O. No metabolic side effects of long-term treatment with verapamil in hypertension. Amplology: 1988;39:1025-1029.

monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecarinide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of herapy in patients with hypertopinic carbonityopamy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase serum levels or cyclosporin. Verapamil may inhibit the clearance and increases the plasma levels of cyclosporin. Verapamil may inhibit the clearance and increases the plasma levels of theophylime. Concomitant use of inhalation anesthetics and calcium antagonists needs careful tritorion to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapami was not mutagenic in the Ames test. Prepanery Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, between the controlled studies in pregnant women. This drug should be used during pregnancy block and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

*Adverse Reactions.** Constipation (7.3%), fizziness (3.3%), nausea (2.7%), hypotension (2.5%), bradycarda: HR < 50/min (1.4%), AV block; total 1*2;*2*3* (1.2%), 2* and 3* (0.8%), syspica (1.4%), bradycarda: HR < 50/min (1.4%), AV block; total 1*2;*2*3* (1.2%), 2* and 3* (0.8%), syspica (1.4%), bradycarda: HR < 50/min (1.4%), AV block; total 1*2;*2*3* (1.2%), 2* and 3* (0.8%), and cleared liver enzymes, virioventifical dissociation, chest pain, claudi-

following reactions, reported in 10% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, strioventricular dissociation, chast plan, claudi-cation, myocardial infarction, palpitations, purpura (vasculitis), syrcope, diarrhea, dry mouth, pastrointestinal distress, gingval hyperplasia, ecchymosis or brusing, cerebrovascular accident, confusion, equilibrium disorders, insonnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somolence, arthraligia and rash, exanthema, hair loss, hyperteratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gineo-mastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, imposence. 4/11/31 - 791CA6277V

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About the Cover

Opportunities for great photographs can be found on every corner in New Orleans' French Quarter. This photo of the "Little Rascal Jazz Band" was taken by IMS staff member Chris Clark on Bourbon Street during the annual New Orleans Jazz Festival in early April. Street musicians, break dancers, mimes and comedians performing for pocket change account for much of the French Quarter's charm.

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April 14, 1992

Dear Doctor:

I am happy to announce the formation of a new company through which I will continue to serve physician members of the Iowa Medical Society.

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I am extremely pleased to have an excellent working relationship with the officers and staff of the IMS and IMS SERVICES. I look forward to serving them and you under our new name and at our new location with the same dedication as we have in the past. On behalf of my long-time staff, particularly Ruth Clare and Terri DeGroot, I invite your inquiries at anytime.

Sincerely yours,

See four to.

Bernie Lowe, Jr., CLU, RHU

President

BL/tad

President's Privilege



R. Bruce Trimble, M.D.

Transition

This farewell Column will be followed next month by an inaugural column by Bill Eversmann, our new president. He will do an excellent job.

It is appropriate in a valediction to re-

flect on the past year.

Among other things, the IMS successfully opposed Medicare "bootstrapping," worked to improve advance directives, helped draft sensible AIDS regulations for health care providers, worked to develop an appeals mechanism for workers' compensation disputes and began an IMS specialty society small area analysis project.

We worked with the AMA to help persuade our congressional delegation to oppose administration attempts to further cut Medicare funding and to pass an "anti-hassle" bill. We began to engage in discussions with other groups on changes in the Iowa health

care delivery system.

The IMS Education Fund provided \$200,000 for medical student loans and contributed to a variety of education and public health projects.

Credit for these achievements goes to the efficient and highly regarded organization

built over the years by strong and widespread physician support, active committee work by hundreds of members and to a very competent and dedicated staff.

These activities, however, were but small, specific actions in long-term efforts to improve public health and defend physician interests. So it has been for 150 years with the Iowa Medical Society. As medicine and society become more complex, what guides us as we pick our way through increasingly complicated problems?

Recently, a patient hugged me. Partly for science and skill, but partly for patience and empathy. In all, for being a physician.

The hug made up for the irritatingly low Medicare visit reimbursement and even for my last exchange with external utilization reviewers.

All of us have had similar experiences. So long as we remember these rewards and work to preserve the circumstances which make them possible, the practice of medicine will be satisfying and the Iowa Medical Society will thrive.

It has been a fast, rewarding and most enjoyable year. Thank you for the privilege.



The Editor Comments



Marion E. Alberts, M.D.

A heritage we cannot ignore

It would be interesting to question physicians about the incentives that prompted each to enter medical training. The motives and aspirations of each individual, to say the least, would be diverse and unique. A second aspect of such a survey would delve into the satisfactions/dissatisfactions and the continued interest in the profession by those physicians.

I pose these questions because in recent years we hear much of the dissatisfaction physicians have with their chosen profession. Is this a result of original misconceptions of what medicine is all about? Has the climate of modern medicine changed so much that changes of attitude have come about in contrast to the original aspirations of the young physician?

A physician has tremendous responsibilities. Those cannot be assumed unless there is wholehearted commitment. Unless that commitment is present, the responsibilities will not be fulfilled in the context of the precepts of the Oath of Hippocrates. Note the precepts of that oath are not a law imposed upon the physician but a moral code of professional conduct. Close scrutiny of the moralistic aspects demonstrate a complexity in that oath. There are several segments of concern. The oath, rather than a sacred witness to a deity, bases the new physician's future on the past historical events of medicine.

The physician recognizes five ethical duties to guide the professional as well as the moralistic life. Those duties are to one's teachers, to society, to the patients, to colleagues and to oneself.

The ethical duties to one's teachers have a reciprocal clause . . . to also be a teacher. In medicine there are no secrets of diagnosis and therapy. We share our knowledge freely. Thereby, we fulfill the second precept that we have a duty to society. Though the present is much more complex than in the days of Hippocrates, all knowledge of clinical medicine goes back to his time. Our task is manyfold over, but nevertheless does exist.

To our patients we hold a great responsibility. We should act toward them as we would want them to act toward us. With our colleagues we share a noble task. In addition to social prestige we gain, together we must strive for the common cause to alleviate pain and suffering; to promote good health and well-being.

No less than the other precepts is the ethical duty we have to promote an ideal profile of oneself and to live in such a manner as to be worthy of the position we hold. We are blessed to have become physicians. We must fulfill our task as scientists with qualities of integrity as human beings . . . quality kindness, high ideals, honesty and efficient concern for our responsibilities.

At death's door: recollections of a medical examiner

When you've been Polk County Chief Medical Examiner for nearly 20 years, you're bound to have some interesting stories to relate. Dr. Wooters recalls some of his 'stranger-than-fiction' experiences and discusses what he's learned about death investigation.

R.C. Wooters, M.D.

Des Moines, Iowa

Author's note: Forensic medicine is a fascinating field; yet, in many Iowa counties, the job of Medical examiner is pushed off onto the new kid on the block. However, I know of county MEs representing many specialties who enjoy the interesting work and the fine people they deal with on a regular basis. I encourage any physician who has an interest to consider becoming involved.

THE PRIMARY FUNCTIONS OF the Medical Examiner (ME) are spelled out in the Iowa Code: to identify deceased persons, to ensure that foul play does not go undetected and to determine the time, cause and manner of deaths falling into predefined categories. Deaths which the ME investigates include: homicide; suicide; accidental death; sudden, unexpected or unexplained death; unattended death and death from a disease or condition which might be a threat to the public health.

In the Code language, this all sounds very matter-of-fact. The reality is far from it.

Thinking like Quincy

I have been involved with medical examiner work in Polk county since 1966, the first seven years as deputy. I was in family practice from 1949 until 1979. When I became chief ME in 1973, I stopped doing obstetrics

and hospital practice. I have investigated over 18,000 deaths including over 300 homicides and 1,000 suicides; I have enjoyed (al-

most) every minute of it.

The Quincy part of the job is fascinating, but only a relatively small part thereof. Most of the cases are natural—sudden unexpected death. I have some difficulty being suspicious of people. Experts are always admonishing medical examiners to think "dirty." Certainly, a prime function of the medical examiner is to assure foul play is not missed. However, I find another aspect equally challenging—providing support for a family that has lost a loved one.

In consoling a grief stricken survivor I have found the following points helpful:

Speak softly and slowly.

 Emphasize that the person did not suffer at the last (if you honestly believe that). I feel most deaths I see are peaceful.

 Provide personal contact—holding the hand, placing a hand on the shoulder, or a

hug if doing so seems appropriate.

 Be a good listener. Don't discourage the survivor from talking about the person and their loss. This applies both immediately

and in the long-term.

 Strongly encourage viewing and touching of the body at the time of death, if at all possible. "Don't you want to hold his hand or kiss him while he is still warm?" Often a badly mutilated or crushed head can be covered with a towel and the loved one can be

allowed to hold a hand. The experts in this field (thanatologists) say a closed casket greatly prolongs the grieving process.

• Discourage the use of tranquilizers and sedatives in most cases—even if well-meaning friends and relatives say, "Doctor, can't you give her something? This is tearing her apart."

• Offer to call a clergy person and/or friends or relatives who might be able to remain after the body has been removed.

 Call the funeral home of the family's choice.

Dodging fists and falling bathtubs

Different people react to being notified of the death of a loved one in different ways. Most often with tears, which can be very effective in releasing tension and emotion and cer-

tainly are not to be discouraged.

Weeping is not the only reaction. I once witnessed a man breaking up a lamp in a hospital quiet room. Another person put his fist through a wall of his home. When I notified one man of his 11-year-old daughter's death, he drew back his fist and swung at me. Seeing this coming, I ducked. He immediately apologized and I told him I understood. (I'm not entirely sure I would have been as understanding if he had connected with my jaw!)

On occasions an individual will become hysterical and may even fall to the ground and scream and kick. In my experience, if circumstances permit, allowing this to run its course while protecting the person from in-

jury is preferable to sedation.

Sometimes the ME's job can be hazardous. Several years ago, I was examining the body of a fire victim in his badly burned home, when a bathtub from the floor above came crashing through the ceiling and landed only inches from me.

Eerie cases, violent death

I have gotten into fleas on a few occasions. The most memorable (?) involved a woman who had been dead for two days. Her seven cats were all outside looking in windows. The electricity was off. As the police officer shined his flashlight across the carpet, one could see the fleas jumping. The officer, the funeral director and I all became infested. After I returned home and removed my

Cause vs. manner of death

There is confusion among physicians and funeral directors regarding the difference between cause and manner of death. According to Dr. Wooters, *cause* is the disease or injury which led to death. There are hundreds of possible causes of death, e.g. coronary thrombosis, lung cancer, gunshot wound of the head, carbon monoxide poisoning, etc.

Manner of death is the circumstance in which the cause arose. There are only six possible manners of death: natural, homicide, suicide, accident, undeter-

mined and pending.

Only an ME or a deputy ME should complete a death certificate on other than

a natural death.

clothing, my wife took a thumb forcep and removed over 100 fleas from my body!

Logistic problems arise at times. A 400-pound man died in a house trailer. To remove his body, it was necessary to get the fire department to use a "K-saw" to cut an opening in the wall.

A pedestrian was struck by a train. I walked the tracks for over a mile recovering

organs and other body parts.

My predecessor, chief and mentor Dr. Leo Luka told of turning over a decomposed and mummified body and having a large rat crawl out of the abdominal cavity.

The tragedy of witnessing a violent death can be very difficult. I recall an 11-year-old boy who saw his father commit suicide by placing the muzzle of a 12-gauge shotgun in his mouth and discharging it. This caused the head to explode. A woman watched as her husband fell from the top of a 400-foot radio tower.

Great rage and "overkill" is sometimes seen in homicide. A woman's body was found along side of a highway with 76 stab wounds of the thorax, abdomen and back. An elderly man was found dead in his apartment with multiple stab wounds of the anterior chest, two dozen incised wounds of the scalp and amputation of the penis. In this case the assailant was a young female high

(Continued next page)

on cocaine and enraged that the victim had already spent his social security check, a portion of which he normally gave to her for sexual favors.

A 16-year-old girl committed suicide by going to a railroad yard and placing her neck on the rail in the path of freight car wheel,

decapitating herself.

Death by carbon monoxide is seen about once a month in Polk County, nearly always the result of suicidal intent but occasionally as the result of a fire or an improperly vented gas heating system.

The classic cherry red color of the skin is typical, but both cyanide poisoning and exposure to cold can also simulate this appear-

ance.

Lethal levels of carbon monoxide may be reached in a closed single garage from an auto exhaust in only 5 or 10 minutes. Internal combustion engines, like human beings, require oxygen to operate. The common situation is to find the dead body in the car in the closed garage with the ignition on — but the motor not running. Inexperienced officers will often conclude that the car ran out of gas — expecially if the battery is dead and the fuel gauge, therefore, shows empty. Several years ago I tested this and found the engine also died of anoxia in 25 minutes in a closed single garage.

Sexual asphyxia — often misdiagnosed

A strange and relatively rare entity that is often misdiagnosed as suicide is the autoerotic death—sometimes referred to as sexual asphyxia. This type of death has been seen throughout much of the world for hundreds of years. I have seen about a dozen cases—mostly young males, but also two females.

The practice is based on a belief that a sexual orgasm can be enhanced by getting into the semiconscious state by interfering with the flow of blood to the brain or using an inhalant such as Freon propellant from an

aerosol can.

The individual usually places a rope about the neck and affixes it overhead with a little slack. He then begins to masturbate and, at the proper moment, bends his knees to tighten the rope. If he maintains this stance for too long, he loses consciousness, sinks into the noose and dies. Hallmarks that should suggest to the investigator that the

manner of death is accident rather than suicide are: a towel or other padding under the rope, the nude condition of the body and the presence of pornographic material nearby. Occasionally, various types of bondage may be seen. Careful inspection of the knots about the wrist will reveal a self-releaseable system.

Sophisticated fingerprinting

Progress in forensic medicine is not as overwhelming or as rapid as in many of the other branches of medicine but it is substantial.

DNA "fingerprinting" is a technique wherein any nucleated cells deposited in or on a victim in the course of an assault and/or homicide can be compared to any nucleated cells from a suspect. A match is considered by many to be virtually positive proof of guilt.

Several convictions in Iowa have resulted from the use of this test. Iowa is still sending the samples to the FBI laboratory in Washington, D.C. Our excellent crime laboratory in Des Moines was forced to put its expansion program for this work on hold

due to the current budget crunch.

Another intriguing technique is that of finding fingerprints on corpses. In this procedure, the body is enclosed in a plastic tent and fumed with cyanoacrylate (super glue) placed on a hotplate within the tent. If a print develops it can be photographed and compared with those of suspects. This technique is relatively new and quite tricky. There are only nine documented cases worldwide where the process proved successful. One such case, wherein a conviction was obtained with the procedure, occurred in Des Moines in September, 1990.

History of Iowa's ME system

Prior to 1961, Iowa had a coroner system. With this system, anyone who could get elected could serve since no scientific training was required. Under that system, the coroner was the highest peace officer in the county and was the only person who could arrest the sheriff! Many funeral directors and others served as coroner. Several states still have the coroner system.

As of 1961, the legislature changed to the medical examiner system. This required that the county ME be a physician licensed to practice in Iowa. The county ME is appointed by the county board of supervisors. Also in

1961, the office of the state ME was established, but was not filled for a number of

years.

In 1968, Dr. Earl Rose, a highly qualified forensic pathologist and attorney, was brought to Iowa from Dallas, Texas. (Dr. Rose was the ME who investigated President Kennedy's assassination, but was not permitted by the Secret Service to perform an autopsy.)

Until his retirement in 1989, Dr. Rose taught in the medical school and the law school at the University of Iowa. Although Dr. Rose was never the official state ME, he served for many years as a mentor and father confessor to many of us about the state who serve as county MEs. He has served as an expert witness in many highly publicized homicide trials.

In 1983, Dr. Thomas Bennett, a native Iowan, returned to his home state after completing a forensic pathology fellowship in North Carolina and agreed to be the state

ME.

Dr. Bennett provides consultation 24 hours a day to county MEs. He also performs autopsies, when requested, on a fee-for-service basis.

A handbook for county MEs which Dr. Bennett wrote in 1984 and updated in 1988, provides concise information for dealing with deaths of various types and is considered the "Bible of Death Investigation" by many local

medical examiners.

With the exception of a year and a half when he went to Mississippi, Dr. Bennett continues to serve as state ME. In December, 1989, he moved to Sioux City, and joined a pathology group but maintains and supervises the state office in Des Moines.

Iowa: a shortage of forensic pathologists

Over the years, hospital pathologists and private pathologists have been and continue to be relied on by county MEs for performance of most of their autopsies. Here in Polk County, pathologists at Broadlawns, Charter, Mercy and Methodist Hospitals have been supportive and helpful over the years.

Most non-forensic pathologists, like other physicians, are naturally reluctant to testify in court. Forensic pathologists, on the other hand, have training in the art of being an expert witness. Many actually enjoy testifying!

There is a paucity of forensic pathologists in Iowa (for that matter, in much of the country). In eastern Iowa there is Dr. Peter Stephens in Cedar Rapids, Dr. Euginio Torres is in southeastern Iowa. In western Iowa, there is Dr. Thomas Bennett in Sioux City

'A 16-year-old girl committed suicide by going to a railroad yard and placing her neck on the rail, decapitating herself.'

and in central Iowa we have Dr. David Gauger and Dr. Francis Garriety — both in Des Moines.

Dr. Gauger, one of three pathologists with the Des Moines branch of the Laboratory of Clinical Medicine, has been very supportive of the concept of enhancing forensic medicine throughout the state. He, along with Dr. Stephens, Dr. Bennett and Dr. Garrity, are members of the Forensic Medicine Committee of the Iowa Medical Society, which held its first meeting in 1990. He and his colleagues, provide pathology services for a number of hospitals in central Iowa.

In July, 1991, Dr. Garrity came to Des Moines from Rhode Island, where he completed a two-year fellowship in forensic pathology. He is a full time employee of the Polk County Health Department and does all of the county's medical examiner autopsies, approximately 150 to 200 per year. His contract also allows him to do out-of-county autopsies on a fee-for-service basis. He is a Deputy Polk County ME and a Deputy State ME. In the latter capacity, he is available for consultation at any time.

Over the years, we have done autopsies in funeral homes, hospital morgues and decomposed cases in garages. I am ecstatic to announce that, by the time you read this, through a joint effort of Broadlawns Hospital and the Polk County Board of Supervisors, we will be operating in a brand new state-ofthe-art morgue.

The morgue is located at Broadlawns Hospital. It is fitted with Lipshaw equipment including a body cooler with space for eight

(Continued next page)

gurneys, an electronic scale for weighing bodies, a twin autopsy unit allowing for simultaneous examinations, a system wherein the gurney becomes the autopsy table and clamps to the sink unit, surgical operating lights and what is reportedly (and hopefully) a highly effective ventilating system.

Educational opportunities

There are three national organizations of interest to medical examiners: the pathology/biology section of the American Academy of Forensic Sciences (there are nine other forensic sections in the Academy), Colorado Springs, Colorado; the National Association of Medical Examiners (N.A.M.E.), St. Louis, Missouri; and the International Association of Coroners and Medical Examiners, Peoria, Illinois.

All of these organizations hold excellent three or four-day annual meetings featuring nationally recognized forensic experts as speakers.

lowa's forensic pathologists

Central Iowa:

David Gauger, M.D., Des Moines Francis Garrity, M.D., Des Moines

Western Iowa:

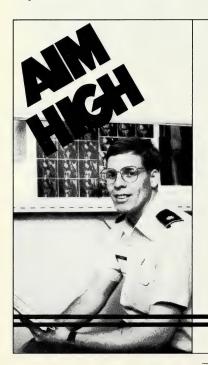
Thomas Bennett, M.D., Sioux City

Southeastern Iowa:

Euginio Torres, M.D., Fort Madison *Eastern lowa:*

Peter Stephens, M.D., Cedar Rapids

A number of excellent training courses are also available around the country. One of the best and closest is the Medicolegal Death Investigator Training Course sponsored by the Division of Forensic and Environmental Pathology of St. Louis University School of Medicine. This is a four-day course provided six times each year.



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Analyzing physician practice patterns

Through a pilot project of the lowa Medical Society, lowa physicians for the first time can get small area analysis data which includes medical interpretation.

Paul Seebohm, M.D.

Iowa City, Iowa

IN 1991, THE IOWA MEDICAL SOCIETY (IMS) created a pilot project, the Iowa Medical Assessment Program (IMAP) which was overseen by the IMS Subcommittee on Utilization Assessment. IMAP analyzes physician practice patterns using small area analysis and provides feedback to individual physicians through study groups.

There are many groups conducting small area analysis in Iowa. However, medical interpretation of the data is lacking. IMAP provides, for the first time in Iowa, the physician expertise to apply medical judgments to small area analysis data. IMAP findings are based on data, current literature and the clinical experience of study group participants.

A key goal of IMAP is to monitor change in physician behavior following each study.

To complete IMAP, the IMS entered into a partnership with Blue Cross and Blue Shield of Iowa (BCBSI) to provide data. BCBSI developed a comprehensive data base which includes inpatient and outpatient data.

IMAP methodologies

IMAP utilizes two proven techniques for studying medical conditions: small area analysis and specialty study groups.

Dr. Seebohm, consultant to the dean of the U. of I. College of Medicine, is chairman of the IMS Subcommittee on Utilization Assessment. Other committee members are: Michael Egger, M.D., Council Bluffs; Paul Rohlf, M.D., Davenport; Gerald McGowan, M.D., Sioux City; Sterling Laaveg, M.D., Mason City; Thomas McIntosh, M.D., Cedar Rapids; and William McMillan, M.D., Ottumwa.

Small area analysis was developed by John Wennberg, M.D. and Alan Gittelsohn, Ph.D. in 1973. The concept is based on comparison of medical practices based on the patient's zip code area.

Specialty study groups—physicians from communities with high, middle and low rates of treatment areas—study small area analysis data for their specialty. The history of these study groups suggests physicians find it beneficial to compare practice patterns. Where data is brought to light and studied, variations in practice patterns become less marked.

Three IMS projects

The IMS selected three clinical areas to test IMAP's potential: knee arthroscopy, adult pneumonia and psychoses. Knee arthroscopy, chaired by Sterling Laaveg, M.D. of Mason City, was selected because all study group participants were of the same specialty (orthopaedic surgeons) and surgical procedures are easily identifiable in computer systems.

Adult pneumonia was selected to test how different specialties work together on a medical condition commonly treated by many physicians. The adult pneumonia study group was comprised of family physicians, internists and a pulmonologist. Thomas McIntosh, M.D. of Cedar Rapids served as chairman.

Finally, psychosis was selected because of its wide variability and higher rate of hospitalization in Iowa. This high rate has been

(Continued next page)

TABLE 1

X-RAY FREQUENCY PRIOR TO
KNEE ARTHROSCOPY 1989 BCBSI CLAIMS

X-ray	No. of			
frequency	cases	Percen		
0	416	28%		
1	803	54%		
2	199	13%		
3	48	3%		
4	8	1%		
5	2	0%		
TOTAL	1,476*			

*Calendar year 1989 BCBSI data are used for this study. The study group believes three months pre-surgical data was needed. Therefore, only cases with knee arthroscopy performed after March 31, 1989 were used for this study.

TABLE 2 NUMBER OF OFFICE VISITS FOR KNEE PROBLEMS THREE MONTHS PRIOR TO SURGERY 1989 BCBSI CLAIMS

Office visit frequency	No. of cases	Percen
0	171	12%
1	371	25%
2	399	27%
3	253	17%
4	122	8%
5	72	5%
6	36	2%
7	20	1%
8	9	0.6%
9	8	0.5%
10	2	0.1%
TOTAL	1,476*	

*Calendar year 1989 BCBSI data was used for this study. The study group believes three months pre-surgical data was needed. Therefore, only cases with knee arthroscopy performed after March 31, 1989 were used for this study.

of considerable public interest. The psychoses study group was chaired by Michael Egger, M.D., Council Bluffs.

Knee arthroscopy

Knee arthroscopy is a new and growing technology. Both diagnostic and surgical arthroscopic treatments are performed. The majority of these treatments are performed on an outpatient basis.

This study revealed variable rates of knee arthroscopy in Iowa. However, these variable rates are secondary to the findings of events associated with knee arthroscopy. Preoperative evaluations include magnetic resonance imaging, x-ray and office visits prior to knee arthroscopy. In this study, BCBSI insurance claims for 1989 were reviewed to characterize knee arthroscopy patients in Iowa.

Orthopaedic surgeons are often faced with uncertainty in diagnosing potential surgical cases. MRIs may become increasingly necessary to assist in making a definitive decision to perform arthroscopy. However, knee arthroscopy and MRIs are both diagnostic tools which should be used judiciously because of prohibitive cost. Duplication of knee arthroscopy and MRIs is minimal in Iowa.

A disturbing finding, shown in Table 1, was that x-rays were performed on only 72% of BCBSI patients prior to knee arthroscopy. Study group members believe knee arthroscopy should not be done without the benefit of an x-ray. Knee arthroscopy or MRIs should be used only after a physical examination and x-ray and with documentation of internal derangement of the knee, malignancy concerns or other problems that have been difficult to diagnose.

TABLE 3

COMPARISON OF BCBSI INSURED PNEUMONIA ADMISSIONS BY COMORBIDITIES

	No. of patients	Readmission rate	Avg age (yrs)	Avg LOS (days)	Avg hosp charge	PMC wgt* (% under 1.0
Uncomplicated	169	0.0%	42.7 ± 13.4	4.7 ± 3.0	\$3,335 ± 4,665	76.9%
W/non-contributory	136	2.9%	44.4 ± 14.0	6.1 ± 5.6	\$5,283 ± 10,092	37.1%
W/malignancy	58	3.4%	56.0 ± 12.2	10.1 ± 9.8	\$8,482 ± 8,595	15.0%
W/chronic lung	131	5.3%	53.9 ± 12.3	7.6 ± 5.0	$$6,902 \pm 7,763$	39.1%
W/metabolic	106	5.7%	50.6 ± 14.1	6.7 ± 4.3	\$5,389 ± 4,394	18.8%
W/oth contributory	152	3.9%	51.0 ± 14.0	7.5 ± 6.3	\$7,049 ± 11,271	13.9%

^{*}PMC wgt is obtained from a software program that measures the severity of inpatient cases. It ranges from 0.0 to 6.0 for these pneumonia cases, with the latter being the most severe and requiring the most hospital resources.

As shown in Table 2, 25% of knee arthroscopy patients had only one pre-operative visit by *any* physician. Knee arthroscopy entails risks, including anesthesia, and should be approached with caution. There is a potential quality concern for a patient to be seen only one time prior to knee arthroscopy. The study group recommends the orthopaedic surgeon should see the patient at least once prior to performing knee arthroscopy.

The knee arthroscopy study has been completed and sent to all orthopaedic surgeons in the state along with their personal rate of knee arthroscopy for BCBSI patients.

Adult pneumonia

Most young patients determined to have mild to moderate pneumonia after a clinical and radiologic assessment can be treated as outpatients, as demonstrated by the repeat admission rate for uncomplicated pneumonia in Table 3. Yet, there is wide variation in the treatment of pneumonia across communities. Adult pneumonia was chosen for study since

it is the third most common cause for Iowa hospital admission in 1989. The IMS study of 777 cases of inpatient adult pneumonia did not include Medicare patients.

Initially, the study group had difficulty classifying the types of pneumonia. With this problem resolved, the study group still found an admission rate of 21.8% for uncomplicated adult pneumonia. This study group continues to look at outpatient pneumonia treatment.

Psychoses

Psychosis is defined as the misinterpretation of reality. However, for reimbursement purposes, psychosis has been defined to include patients who are not actively psychotic. This causes large discrepancies in data collection and affects reports concerning the cost and length of stay for psychoses admissions.

The rate of psychiatric hospitalization in Iowa has been a subject of long-standing public policy debate. This study offers statistics that confirm the higher use of psychiatric

(Continued next page)

TABLE 4

COMPARISON OF SAM-GRAPH AND BCBSI DATA, 1989 PSYCHOSES ADMISSIONS

Area (1)	1989 SAM-Graph (2) admissions/1000	1989 BCBSI admissions/1000	SAM-Graph rank	BCBSI rank
Manchester	2.26	4.29	31	1
Red Oak	2.32	3.69	28	2
Denison	1.68	3.43	41	3
*Osage	1.82	3.43	40	4
Muscatine	2.89	3.29	21	5
Newton	3.98	3.21	8	6
*Cedar Rapids	4.69	3.14	4	7
*Council Bluffs	3.43	3.00	15	8
*Mason City	4.84	2.91	2	9
*Clarinda	2.61	2.75	26	10

⁽¹⁾ Asteriks indicate areas with more than one hospital.

TABLE 5
1989 BCBSI PSYCHOSES ADMISSIONS

	No. of patients	No. of cases	Readmission rate	Avg age (yrs)	Avg LOS (days)	Avg hosp charge
Schizophrenic disorders	118	154	30%	35.6	19.7	\$5,931
Affective psych single episode	507	590	16%	32.9	18.1	\$6,904
Affective psych recurrent episode	340	439	29%	39.1	18.9	\$7,191
Affective psych bi-polar and oths	249	330	32%	39.9	18.9	\$6,208
Paranoid and oth psych	60_	65_	8%	41.7	13.5	\$5,159
	1,274	1,578				

⁽²⁾ The SAM-Graph crude rate was recalculated to match the 48 large areas of the BCBSI data.

hospitalizations for which the study also found some possible solutions.

Table 4 shows the top 10 geographical areas of psychoses admissions according to BCBSI data. Also shown is the ranking according to SAM-Graph, a statewide database. Note the ranking discrepancies between the two. The study group concluded that insurance benefit design and community attitude toward local treatment strongly influence psychoses admissions.

Patients diagnosed under DRG 430 psychoses are not clinically similar and their treatment requirements differ significantly. For example, patients with major depressive disorders are listed under DRG 430 but these patients are not always psychotic. DRG 430 also includes active psychotic patients in

need of life-long treatment.

The study group recommended more specific categories of illness be used in describing psychoses with the BCBSI claims data base. As shown in Table 5, five categories were developed, grouping ICD-9 codes which are clinically similar to form groups with sufficiently large numbers of claims to yield meaningful statistical analysis.



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Questions and Answers



Thomas Bennett, M.D.

More forensic pathologists needed, says state medical examiner

Iowa's state medical examiner, a Sioux City pathologist, discusses the duties of his office and the DC 10 crash which tested the system.

What is the role of the state medical examiner?

The state ME's duties, as outlined in the Iowa Code, are to teach, investigate, consult, keep records and promulgate rules and regulations.

The state ME should teach forensic pathology and provide training to officials who deal with death investigations, namely law enforcement, health care personnel including emergency personnel, the legal profession and others. Much of this teaching can be in the form of simple consultation when working with death investigators on a case where the death is sudden, violent, unexpected, suspicious or unattended. A phone call may often be just the amount of intervention required.

The state ME is required to investigate every sudden, violent, unexpected death (i.e. "the deaths which affect the public interest"). Because Iowa is a large state, this cannot usually be done on a firsthand basis. Rather, the state ME serves as a consultant to county MEs.

The promulgation of rules and regulations is a statutory duty which has been addressed

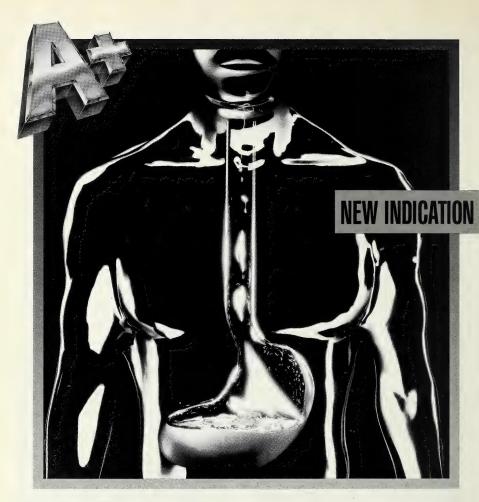
primarily through publication of the "Handbook for MEs," published with the assistance of the Department of Public Safety.

How could the state ME system be improved?

Depending upon volunteer professional services on a long-term basis is not sound policy. Our statutes indicate there should be an individual providing these services; the services and duties are well outlined. The state ME system could be improved by providing more forensic pathologists, with adequate supportive staff including investigators, autopsy and laboratory assistants and secretarial staff, etc.

Because our state logically divides into three regions (east, central and west), a regional approach to constructing ME services and facilities would be reasonable, in my opinion. This would take considerably more funding than the current \$30,000 per year, but would be well worth the cost in the great benefits of increased service, promptness and available expertise.

(Continued next page)



ONLY ONE H-ANTAGONIST HEALS REFLUX ESOPHAGITIS AT DUODENAL ULCER DOSAGE. ONLY ONE.

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Brief Summary. Consult the package insert for complete prescribing information.

compiete prescribing information. Indications and Usage: 1. Active duodenal ulcer— for up to 8 weeks of treatment at a dosage of 300 mg. hs. or 150 mg b.d. Most patients heal within 4 weeks. 2. Maintenance therapy—for healed duodenal ulcer patients at a dosage of 150 mg. hs. at bettim: The consequences of therapy with Axid for longer than 1 war are not known.

year are not known.

3. Gastroesophageal reflux disease (GERD)—for up to 12 weeks of treatment of endoscopically diagnosed esophagitis, including erosive and ulcerative esophagitis,

and associated heartburn at a dosage of 150 mg b.i.d. and associated meanuring at a usage of 150 mg bxx.

Contraindication: Known hypersensitivity to the drug.

Because cross sensitivity in this class of compounds has been observed, H₂-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H₂-receptor antagonists.

Precautions; General – 1. Symptomatic response to nizatidine therapy does not preclude the presence

been observed. Hy-reception antiagonesis, including Axiv, should not be administered to patients with a harbory actual control of the presence of pastic malignancy.

Prezaultions: General—1. Symptomatic response to nizabiline therapy does not preclude the presence of pastic malignancy.

2. Dosage should be reduced in patients with moderate to severe rereal insufficiency.

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2. Dosage should be reduced in patients with moderate to severe rereal insufficiency.

3. In patients with normal real function and uncomplicated repetate dystulction, the disposition of nizabiline in similar to his him normal sobulect.

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A valuely of less common events were also reporter, it was not possible to bettermine whereix reserve caused by microlations.

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hepatitis and jaundice have been reported. Rare cases of chelestatic or mixed hepatice:liular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid. Cardiovascular—Indicate pharmacology studies, short episodes of asymptomatic ventricular factycartia occurred in 2 indicate pharmacology studies, and controlled conflicts of the controlled conflicts of Indicated pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to macradine, impolence and discressed failod were reported with smillar frequency by patients carbidly due to macradine. Impolence and discressed failod were reported with smillar frequency by patients on macradine and those on placeto. Gynecomaste has been reported ranky. plactic-or-terated pharmacology.—America was reported any placet in reader with macradial man and the first patients. Failal thromology opens was resported any applicative tracked with macradial and another fy-receptor platents. Failal thromology opens was resported any applicative tracked with macradial and another fy-receptor platents. Failal thromology opens was resported any applicative tracked with macradial and another fy-receptor platents.

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edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausae related to nizatidine have been reported.

natissal evaluation of initial other new usern reported.

"Overflosage" Correloses of And have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodicipies to remove inzatiliate from the body has not been conclusively demonstrated; however, due to large volume of distribution, nazalidine is not expected to be efficiently removed from the body by this method. PV 2093 AMP [101591]

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What has been your most unusual case?

It involved a girl who was kidnapped, sexually assaulted repeatedly, accidently killed (probably through asphyxiation in a closed oil drum), bound and thrown into a creek where her decomposed body was found. This was not an Iowa case.

Dealing with the prejudices of local law enforcement, townspeople and other investigators and with their unwillingness to even consider ideas given to them by the FBI, forensic pathologists and other investigators was frustrating. The case is unsolved. The case itself was unusual but the way it was handled with such poor cooperation among the various agencies stands out in my mind, and still is the most frustrating aspect.

How often is foul play missed as a cause of death?

I don't believe foul play is missed very often. If anything, death investigators are so cautious they will suspect foul play early on and wait for it to be ruled out. This is the wisest and most prudent way to approach any death investigation. James Benz, former ME in Indianapolis, taught us to "think dirty" because we would rarely be surprised that way.

The most profitable investigation is the early investigation. Discovering foul play late in the investigation means much of the evidence and information is already lost or destroyed. I am proud of death investigation in Iowa, where law enforcement has been especially effective.

What was learned about the state's medical examiner system during the days following the crash of the DC 10 in Sioux City?

During the days following the crash of the DC 10, we learned that Iowa's ME system is heavily dependent upon very altruistic and capable people who are willing to serve, often at great sacrifice.

We don't really have a state "system" in Iowa. Rather, we have individuals who are willing to work together in a crisis. We all pulled together during the crash and I am confident if a similar crisis happened we would all pull together again.

This is the result of the ethics of the people rather than the structure of the system. Because of this, however, the rest of the nation is still studying how the crisis was handled as an example of what can and should be done.

Safety awareness project

As more people become involved in fitness and there are runners, walkers and bikers on streets day and night, the "Stride Identified" health project of the Polk County Medical Society and Auxiliary becomes even more important.

"Stride Identified" is a replication of the safety awareness project inspired by an accident involving a young woman in Minnesota. The woman was hit by a car and admitted to the hospital unconscious and badly injured. Carrying no identification, and in a coma, she became a "Jane Doe" for several hours.

To prevent future mishaps, a tag to be worn on both shoes with laces was developed. These tags allow identification to be written on one side and have a 3M-made reflective and water-repellent surface on the other.

Individual packets (2 tags) may be obtained from the Polk County Medical Society for \$1.25 or 25 packets for \$21.00. Send requests to: Jo Brown, 4 Foster Drive, Des Moines, Iowa 50312.

Alan Nelson M.D. takes helm of American Society of Internal Medicine

Alan Nelson, M.D., assumed the position of executive vice president of the American Society of Internal Medicine (ASIM) on March 26, 1992. Dr. Nelson, an internist from Salt Lake City, Utah, succeeds Joseph Boyle, M.D.

As the chief staff executive at ASIM, Dr. Nelson will oversee a national medical specialty society which represents more than 26,000 internists nationwide.

Prior to assuming his full-time position at ASIM, Dr. Nelson was in the private practice of internal medicine and endocrinology in Salt Lake City. He is a past president of the AMA (1989-90) and served for several years (1980-91) on the AMA Board of Trustees. Dr. Nelson is also currently serving a one year term as president of the World Medical Association (WMA). WMA is an organization of representatives from national medical associations in some 55 nations.

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Letter to the Editor

Comments, speculation about February issue

Dear Editors:

Was Dr. Gachet despondent? The van Gogh portrait of the French homeopath/psychiatrist, Paul Ferdinand Gachet, is a graphic lead-in to interesting and timely articles on physician depression and suicide printed in the February edition of IOWA MEDICINE. Vincent van Gogh's portrait of Dr. Gachet and his letters suggest the French doctor was clearly depressed or desponent. The visual impact of the portrait and its historical interest are confirmed by the fact that at one time this was the highest-priced painting offered at public auction.

There is a clinical question of interest. Was Dr. Gachet in fact depressed and desponent or did van Gogh, who suffered from a mood disorder and took his life two months later, see him that way? We do not have Dr. Gachet, who lived to be over 80 and apparently died of natural causes. What we have is van Gogh's impression of his treating physician. Depressed patients frequently see others as depressed and the world as a miserable place.

Clifford Beers, who suffered from manic depressive psychosis and whose life work led to the founding of the National Mental Health Association, adds testimony to this point. He reports in his book *The Mind That Found Itself* that when he was first admitted to the hospital, he saw the doctors and nurses as insane. As his condition improved they appeared to regain their sanity.

This is not to deny that physicians become depressed or suicidal. The articles in IOWA MEDICINE clearly reflect the national literature. Physician depression/suicide is an important problem, but I suggest that despondency does not always provide a clear view of the world and further, there is a clinical point in all of this. When patients indicate that they see their physician as depressed, besides reflecting on the truth of this assertion, the doctor should also consider whether this may be a clue as to how the patient is seeing himself and his world. Misery like beauty can lie in the eye of the beholder.

— Jack Dodd, M.D., Ames.

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pributary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it, however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may

have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly, must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants; or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nauses and vomiting are common after parenteral administration of the drug. 1.2. Also dizziness, headache, skin flushing reported when used orally. 1.3.

Desage and Administration: Experimental dosage reported in treatment of erectile impotence. 1.3.4 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausse, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks. 3

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

deferences.

- A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
 Goodman, Gilman — The Pharmacological basis
- of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85. 3. Weekly Urological Clinical letter, 27:2, July 4,
- 3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
- A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Recent Books

Hofreuter, Donald H., editor, The Higher Ground: Medical Ethics and the Physician Executive, 1991, American College of Physician Executives, Two Urban Centre, Suite 200, 4890 West Kennedy Blvd., Tampa, Florida 33609. The clinical implications of ethical decision making are emphasized in this series of essays. The decisions of physician executives constantly involve a balance between the "needs of the patients and the needs of organizations for fiscal soundness and stability." This forum is highly recommended for physicians in the position of having to make such decisions.

Couch, James B., editor, Health Care Quality Management for the 21st Century, 1991, The American College of Physician Executives, Two Urban Centre, Suite 200, 4890 West Kennedy Blvd., Tampa, Florida 33609. The editor brings together a series of presentations by diverse leaders in health care quality management. Issues are discussed and methods proposed to resolve health care costs, quality and access. The coverage is broad, yet much detail is presented. The message is clear that physician executives are more aware of this extremely important aspect of health care—quality.

Peiken, Steven, Gastrointestinal Health, 1991, Harper-Collins Publishers, New York, New York, \$19.95. This self-help nutritional program for better gastrointestinal health is for the lay reader. The author is an advocate of a diet high in fiber and low in fat, spices, lactose and caffeine. The book discusses gastrointestinal physiology, and various disorders of the digestive tract followed by a program to alleviate symptoms. Numerous recipes are also included.

Cohan, Carol, June B. Pimm and James R. Jude, 1991, *A Patient's Guide to Heart Surgery*, revised edition, Harper-Collins Publishers, New York, New York, paperback, \$9.95. A well-written, informative guide which is to help patients understand the psychological stress of heart surgery. This revision makes a point that heart disease is more prevalent in women than earlier recognized. This book is recommended for the patient and family members.

Evaluating Total Parenteral Nutrition: Final Report and Statement of the Technology Assessment and Practice Guidelines Forum, Georgetown University School of Medicine, Washington, D.C., January 10-11, 1991. A forum was invited to establish practice guidelines for health care providers on techniques for total parenteral nutrition (TPN). Various indications were considered in the light technology, efficacy, safety and indications as well as concerns about economics of TPN and the ethical and legal issues. The forum members represented the specialties of surgery, pediatrics, internal medicine, nursing, nutrition, statistics, research methodology and policy analysis. Hence, the subject was considered in depth and the final conclusions should be a valuable guide to all practitioners involved in providing this modality of therapeutics.

Books primarily of interest to lay persons:

- Gross, Amy and Dee Ito, Women Talk About Breast Surgery, 1991, Harper-Collins Publishers, New York, New York, paperback \$10.95.
- Dachman, Ken and John Lyons, You Can Re-

lieve Pain, 1991, Harper-Collins Publishers, New York, New York, paperback \$9.95.

- Pantano, James A., Living with Angina, 1991, Harper-Collins Publishers, New York, New York, paperback \$9.95.
- Longbotham, Lori, Quick and Easy Recipes to Boost Your Immune System, 1991, Avon Books, New York, New York, paperback \$3.95.
- Harrington, Geri, The Asthma Self-Care Book, 1991, Harper-Collins Publishers, New York, New York, \$19.95.
- Fisher, Jeffrey A., The Chromium Program, 1991, New York, New York, paperback \$9.95.
- Fisher, Stanley, Discovering the Power of Self Hypnosis, 1991, Harper-Collins Publishers, New York, New York, \$19.95.
- Gershoff, Stanley, *The Tufts University Guide to Total Nutrition*, 1991, Harper-Collins Publishers, New York, New York, paperback \$12.95.
- American Council on Science and Health, Summer Vacation Handbook: Health and Safety Tips for Your Summer Vacation, 1991. Contact American Council on Science and Health, 1995 Broadway, 16th Floor, New York, New York 10023-5860.

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ULCER DRUG RECEIVES NEW INDICA-TION FOR GERD—Pepcid® (Famotidine, MSD), the Merck H₂-receptor antagonist for the treatment of active duodenal and benign gastric indicated ulcers, has received a new indication for short-term treatment of patients with symptoms of gastroesophageal reflux disease (GERD) and patients with erosive esophagitis diagnosed by endoscopy. Symptoms of GERD may include chronic heartburn, regurgitation of acid into the mouth, pain or difficulty in swallowing or unexplained cough. In a 12week study of 376 patients with symptoms of GERD and without endoscopic evidence of erosion of ulceration of the esophagus, 69.9% of patients taking Pepcid® 20 mg twice a day experienced moderate or excellent relief of nighttime and daytime heartburn by two weeks. By six weeks, 81.8% experienced symptom relief. In a 12-week study of 318 patients with endoscopically confirmed erosion of ulceration due to GERD, two dosage strengths of Pepcid®—20 mg twice a day and 40 mg twice a day—were compared with placebo. By 6 weeks, 48% of patients taking Pepcid® 40 mg twice a day experienced endoscopically confirmed healing, compared with 32% taking 20 mg twice a day and 18% taking placebo. By 12 weeks, 68% of patients taking Pepcid® 40 mg twice a day showed endoscopically confirmed healing, compared with 54% taking 20 mg twice a day and 29% taking placebo. Pepcid® has shown excellent tolerability in controlled trials, with a low incidence of side effects, even at higher doses. Adverse reactions reported in more than 1% of patients included headache (4.7%), dizziness (1.3%), constipation (1.2%) and diarrhea (1.7%).

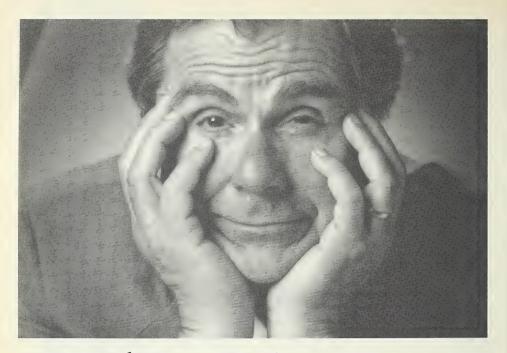
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Diagnosing breast cancer: progress and problems

Earlier diagnosis of breast cancer has raised new questions about appropriate treatment and reconstruction. Revised guidelines for mammography are also discussed.

Donald Young, M.D.

Solon, Iowa

THIS YEAR, 180,000 NEW CASES OF breast cancer will be diagnosed in American women; 2,300 in Iowans. Nationally, and in Iowa, a 32% actual increase in the disease has occurred over the past 10 years. This is due to our aging population, better detection techniques and, to a lesser degree, life-style factors such as delayed childbearing and diet.

A greater number of curable lesions are being diagnosed early, giving us the opportunity to utilize breast conserving surgery. With a few exceptions, treatment of breast cancers under 1 cm in size, which are usually non-palpable, is less extensive and less expensive. Mammography is now the most frequent patient requested radiologic exam in the United States, demonstrating the effectiveness of public and professional education efforts by organizations such as the American Cancer Society.

Confidence in the value of a properly performed and interpreted mammographic exam continues to be strengthened by strategies to maintain and improve quality coupled with a significant reduction in prior barriers, such as radiation risk, cost and accessibility. Study after study, however, consistently suggest that screening mammography is under utilized. Lower income and less educated women living in a rural setting who have not seen a physician in the past year are the least likely to have had a mammogram. The National Cancer Institute has set cancer control goals for the year 2000 that include participation of 80% of all eligible women in mammographic screening.

Guidelines should be revised

Guidelines for screening mammography recommended by the National Cancer Institute, American Cancer Society and American College of Radiology are:

- Age 35-40: A baseline exam at which time a few unsuspected cancers will be found.
 However, the primary value of this initial study is to serve as a basis for comparison when future exams are obtained.
- Age 40-50: Follow-up studies, every one-two years, modified by known risk factors.
 Age 50 and above: Annual follow-up ex-

ams.

Mortality reduction studies on the Breast Cancer Detection Demonstration Project participants show on an observed *vs* expected re-

Dr. Young is a radiologist specializing in the diagnostic aspects of breast diseases with the University of Iowa College of Medicine.

THE IOWA MEDICAL FOUNDATION HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION AWARD FOR MAY 1992 duction of 11% in the age group 35-49, 24% in age group 50-59 and 26% in ages 60-70 with at least nine years follow-up. Interestingly, no studies have reported a mortality reduction in women age 40-49 because only intermediate or slower growing cancers were detected with the less frequent exams, missing the aggressive, rapidly growing lesions which tend to occur in younger women.

I am in agreement with physicians who support revision of existing guidelines, especially in women with one or more major risk factors. Awareness of major risk factors, which are additive, including premenopausal breast cancer in a mother or sister, early menarche, late menopause, first full-term pregnancy after the age of 30, etc., mandates modifications of existing guidelines. Specifically:

• Advance baseline examinations by 10 years in premenopausal women whose mother and/or sisters who have had breast cancer.

 Annual mammography for women age 40-49 with one or more major risk factors, interpreted in conjunction with clinical examination of the breast and instruction on breast self exam and possible preventive measures.



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 Annual exams in women with prior biopsy findings of atypical hyperplasia, especially the premenopausal group.

Breast implant controversy

Recent media publicity concerning technical and professional quality control aspects of mammography, the breast implant controversy and advances in supplementary diagnostic

'Mammography, even if perfectly positioned, processed and interpreted, frequently cannot separate a benign from a malignant process.'

techniques such as breast ultrasound and needle biopsy are resulting in a new patient care role for some radiologists. Traditionally, the role of a radiologist has been that of a consultant; however, especially with patient initiated requests, the role becomes nontraditional and for some uncomfortable. Patient requests for mammography, permitted by Medicare, require the radiologist to recommend and/or perform an appropriate physical exam, provide the patient with a report and if positive findings are present, advise further evaluation and/or follow-up. Obviously, the medical/legal implications are different when there is no referring physician.

Mammography, even if perfectly positioned, processed and interpreted, frequently cannot separate a benign from a malignant process. Under this circumstance, an open surgical biopsy is usually performed though needle and core biopsy techniques which permit accurate morphologic characterization in selected cases are available. All biopsy techniques are extremely safe.

The economics of health care are focusing on the positive predictive value (PPV—number of cancers found per number of biopsies performed) of mammographically directed biopsies and those done solely on the basis of clinical findings. Generally, the PPV for mammographically directed biopsies is somewhat higher than those done on a clinical basis; the

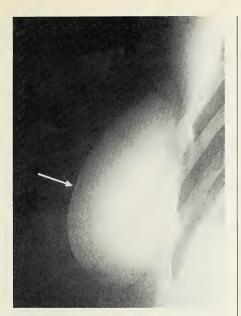


Figure 1. Special view of retroglandular silicone gel implant with capsular calcifications.

mammographically directed procedures usually find cancers at an earlier stage.

Controversy continues about the importance of ductal carcinoma in situ (DCIS) and lobular carcinoma in situ (LCIS) as to whether an invasive lesion will develop. Until the natural history of either lesion is better known, both should be separately classified in breast cancer statistics.

Silicone gel widely used

Silicone gel breast implants were introduced 30 years ago and have only recently been regulated; they were on the market before Congress amended the Food, Drug and Cosmetic Act in 1976 to include medical devices. Approximately two million American women have had breast implants, though other silicone gel devices are also widely implanted in the human body.

Silicone gel breast implants used for reconstructive, cosmetic or augmentation purposes, slowly lose some silicone via an osmosis-like process. When phagocytized by macrophagizes, silicone is carried to regional lymph



Figure 2. Galactogram in patient with galactorrhea and silicone implant exhibiting benign duct ectasia.

nodes where a foreign-body giant cell reaction may develop. Implants manufactured since 1981 have a lower "bleed" rate and a salinefilled device and autologous soft tissue reconstructive procedures provide additional options.

The incidence of deflation or rupture appears to increase with time. Rupture can occur spontaneously or secondary to trauma; however, rupture during mammography, though reported, is extremely rare. Mammographic evaluation of the cosmetically-altered breast should be tailored to the implant type and location. Special views are usually required and some mammographic units can be adapted to view the entire implant for rupture. Rare reports of connective tissue disorders (scleroderma, lupus and rheumatoid arthritis) have been linked with gel migration. However, the reported number of incidences is no greater than in the general population in the same age group. Breast ultrasound is frequently helpful in separating true breast abnormalities from bulges or wrinkles in the implant.

(Continued next page)

Galactorrhea, especially spontaneous from a single orifice and bloody, requires additional imaging studies after cytology. If initial mammograms are normal, galactography is usually of value to demonstrate the cause and location of the abnormality. In the larger ducts, papillomas, ductectasia, non-papillary ductal epithelial hyperplasia or duct carcinoma can be found. In the smaller ducts and terminal duct lobular unit, the same findings as well as cystic changes may be observed. At all ages, the most common cause of a serosanguineous or bloody discharge is an intraductal papilloma.

The combination of quality breast exams and happy patients sets the stage for the best opportunity to detect curable breast cancer through regular follow-up studies. Success in achieving high standards and maintaining patient rapport is enhanced by a sincere commitment to patient education and direct involvement of our patients in decision making, where

appropriate.

Editors' note: A list of resource materials used for this article is available from the author or the editors. For the woman who wants meaning to her practice and balance in her life.



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Burying the dead

Richard M. Caplan, M.D.

I FINALLY MANAGED TO ATTEND the annual ceremony during which our anatomy department inters the cremated remains of those who had volunteered their bodies for medical study and research. I'd heard it deserved high regard as a memorial service,

and I certainly found it so.

The event was ecumenical, fittingly so, considering the diversity of those being remembered, and of their families and friends in attendance. The service was slightly theistic, but only a little, I suspect out of regard for the multiplicity of belief systems represented. And even if one can't satisfy everybody all the time, the tastefulness and appropriateness of the occasion and the comments seem to me to warrant high praise.

The solo voice of a violin singing Bach, splendidly played by a sophomore medical student, floated on the lovely warm afternoon near the end of summer. The sloping green hillside was dotted with a surprising number of attendees. Eulogies were generic, told feelingly by the head of the anatomy department and students representing medicine, dentistry, physical therapy, nursing and graduate students. Closing words were offered by a hospital chaplain. The emphasis by all speakers addressed, suitably, the profound contribution of the donors and the enormous value of the gift to all the students and investigators, and through them and their careers to patients and society broadly.

Attending a funeral from time to time is a salutary *memento mori*, a reminder of one's mortality. Such reminders are needed to make us pause for at least a few minutes of introspection. They can, should, and do cause life—day by day—to seem more valuable. How do we, or should we, lead our lives,

which activities are worth giving time to, which values are the ones to nurture, which the relationships to foster? For those family members attending, the emotional responses must have varied greatly, but likely included appreciation for the efforts made to provide suitable, meaningful closure to the lives of their loved ones.

The event of the day plus those decisions, hopes, and logistics that led all those people to be present there evoked for me memories of my own freshman course in gross anatomy, where I learned the names and relationships of parts of my cadaver but also of my classmates. I recalled, too, being surprised at how long my left index finger kept bleeding after I gashed it one day during dissection. Other thoughts reflected on the history of human dissection and how, through most of the centuries of Western experience, it had been prohibited. I remembered learning that Galen described the hands of Barbury Apes rather than humans, and walking down the Edinburgh Street where Burke and Hare in 1824 seized harlots and homeless to provide salable corpses to the professor of anatomy.

The words of the speakers evoked for me ideas about free will, altruism, religious beliefs concerning the end of days, the role and rules of laws governing burial and the modes of preserving the body (from the embalming resins and carnoptic jars of ancient Egypt to the beautifully constructed pyra-

mids of Meso-America).

I experienced a mental swirl—the diagnoses that caused these deaths; the anatomic, pathologic and linguistic techniques for deciding those diagnostic names; the many ideas and images from history, anthropology, poetry, law, religion, narrative, philosophy and engineering that govern the decisions of doctors, patients, and societies. It was indeed an hour in which the realities and necessities for studying the medical humanities were full upon me. And it felt just right.

Dr. Caplan is Coordinator, Program in Medical Humanities at the University of Iowa College of Medicine.

Scenarios involving confidentiality

Robert Weir, Ph.D.

A RECENT ARTICLE IN THE Journal of Clinical Ethics described a survey on confidentiality done in one of the nation's leading clinical centers. The survey findings may encourage you to think about the importance of confidentiality in physician-patient relationships, even though some of the scenarios may not be common in your practice. In my next column, I will discuss several aspects of confidentiality and provide ethical criteria for the rare times it is morally necessary for a physician to breach confidentiality.

The survey was done at the clinical center of the National Institutes of Health (NIH). In the survey, several scenarios were described. Physicians and nurses participating in the survey were asked to respond to each scenario by indicating the behavior they believed they *should* practice, and by stating what they thought they *would* do if faced with the situation.

Scenario 1: A physician receives a telephone request from a patient's friend to disclose information about the patient's medical condition. Most physicians in the survey (94%) stated they *should* refer the caller to the patient or patient's family for information; 90% said they *would* do so.

Scenario 2: The physician of an adult patient with a terminal condition is asked by the estranged parents of the patient to disclose the patient's diagnosis. Most physicians (96%) indicated they *should* discuss the request with the patient first; 85% said they *would* contact the patient first (9% said they would tell the parents).

Scenario 3: A physician (or nurse) overhears a conversation in a hospital elevator regarding the details of a patient's case. Most persons (88% of nurses, 78% of physicians) responded by saying they should gently interrupt and say, "I don't think you should discuss this here." By contrast, only 18% of all respondents said they would do this.

Scenario 4: A physician (or nurse) notices an unidentified person at the nurses' station reading a medical record. Most responders (92% of nurses, 74% of physicians) stated they *should* introduce themselves and inquire as to the identity of the reader (another 15% of physicians said they should refer the problem to the head nurse or take the chart away). However, only 60% of physicians (and 85% of nurses) said they *would* do something to protect patient confidentiality in this situation.

Scenario 5: A patient requests biopsy results from a physician during a conversation in the cafeteria. Most physicians (92%) agreed they *should* not discuss the request in the cafeteria, but make an appointment to see the patient in the clinic; almost as many (89%) said they *would* follow that course of action.

Scenario 6: A patient who is HIV positive has not told his fiancée about his health status. Most physicians (90%) indicated they should tell the patient of his obligation to inform his fiancée; 86% said they would do so. The option of the physician informing the person at risk for harm was not given in the survey (this scenario was written prior to development of policies regarding notification of sexual partners of HIV-infected patients when the patient is unwilling or unable to inform the partner).

What about your practice? What situations challenge you the most in trying to protect patient confidentiality?

Dr. Weir is director of the program in biomedical ethics for the University of Iowa College of Medicine.

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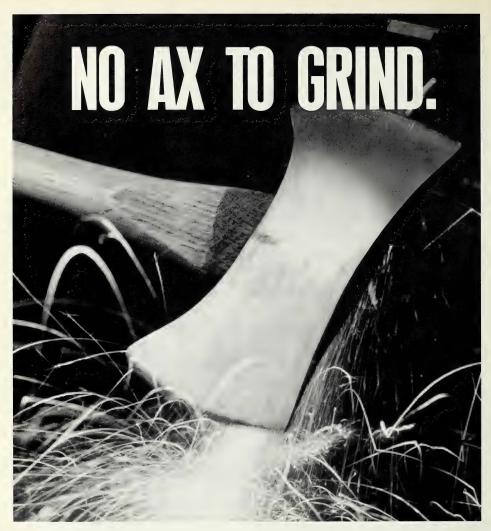
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Hiring a clinic manager

THE ROLE OF A CLINIC MANAGER today cannot L compare with that same role five to 10 years ago. Health care is changing; skill and perseverance are required for your practice to

The clinic manager should be an extension of the physician and/or the physician governing board, but your manager needs clear direction and to achieve the desired results for your medical practice.

Pre-interview planning

Before interviewing candidates for clinic manager, prepare a detailed job description which clearly denotes the amount of control you are willing to relinquish to the manager in fulfilling various tasks. This will give the candidate clear understanding of your expectations and the role of the office manager in your organization. The job description will also provide you with a good tool to use during the manager's annual performance review/evaluation.

As you review the job description, make sure you are not attempting to retain too much control. The purpose of a clinic manager is to allow you more time to practice medicine.

The following considerations are im-

portant in the selection process:

 Is the candidate knowledgeable regarding changes in insurance company rules, Medicare regulations, ICD-9 and CPT codes and OSHA requirements?

 Does the candidate know how to implement changes which will place the practice in compliance with third party requirements?

 Does the candidate understand what information must be documented in the patient's medical chart, what may/may not be released and rules regarding confidentiality?

 Is the candidate familiar with the laws regarding hiring and firing of practice personnel and other legal considerations regarding employees?

 Does the candidate have the communications skills necessary to deal effectively with

staff, patients, vendors, etc.?

 Does the candidate know how to structure the office so the best possible image is projected to the public? Is the candidate knowledgeable about scheduling for office staff and patients? Does the candidate have knowledge regarding computers?

Does the candidate have the necessary

skills in the area of finances?

Common mistakes

Many times, as a practice grows, a physician may reward a loyal employee with the position of clinic manager. However, that person may not have the appropriate training or necessary skills to do the job. The manager's job requires an abundance of knowledge in a variety of areas. Make sure your candidate's qualifications meet the business needs of your practice.

Also, salary level should not be the only consideration in hiring a manager. You generally get what you pay for and the major emphasis should be on the abilities and strengths of the individual. Hire the candidate who meets your criteria and whose salary is within your

Working with your manager

 Allow the new manager to be innovative and creative, following the goals outlined in the job description.

 Establish open communication between the governing partner and the clinic manager. The manager should feel the managing partner is available at any time to answer questions.

(Continued next page)

This article was written by Charlene Cooper, chief executive officer for Iowa Orthopaedic Center in Des Moines. She is a member of the Iowa Medical Group Management Association.

The physician and the clinic manager need to have weekly meetings even if they are brief

meetings.

• Encourage your manager to attend meetings with peers and keep abreast of changes in health care delivery. Observing the management techniques of others is also valuable. Iowa has several management groups and your manager should attend their meetings. Ask your manager about the content of the meetings they attend. Be interested.

Praise your manager for a job well done.
 A manager needs to know you value his or her

contribution.

• Don't help your manager fail by allowing staff members to go over the manager's head and bring routine matters to you. Look for ways to help your manager succeed. Make suggestions regarding the staff, not demands. Let your staff know you have given your manager the authority to do the job.

You don't need a manager who enables you to continue making all the business decisions. You need a manager who has creative, fresh ideas and is an office leader.



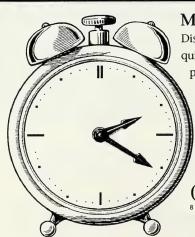
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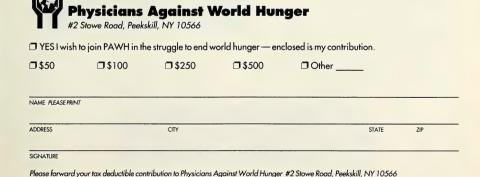
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About Iowa Physicians

Items in this column are compiled from newspaper clippings from the Iowa Press Clipping Bureau. News from individual physicians, clinics and hospitals is welcomed and encouraged.

Dr. Richard Kuehn has joined the staff at Sheldon Family Practice Associates, Dr. Kuehn received the M.D. degree from the U. of I. College of Medicine and completed internships at Mountain View General, Tacoma, Washington and San Bernadino County Hospital, San Bernadino, California. Dr. Kuehn had been in private practice in Corvallis, Oregon for 29 years. Dr. Ming Chan has joined Mater Clinic in Knoxville. Dr. Chan received the M.D. degree from Taipei Medical College, Taipei, Taiwan and completed a general surgery residency at St. Vincent's Medical Center, Bridgeport, Connecticut. Prior to locating in Knoxville, Dr. Chan practiced with Kaiser Permanente Medical Group in San Jose, California. Dr. Charles Helms, professor of internal medicine at the U. of I. College of Medicine, has been named to the national vaccine advisory committee. The committee will advise the director of the National Vaccine Program in the Department of Health and Human Services. Dr. Robert Bischoff has joined Dr. Frank Lamp at the Family Health Center in Grundy Center. Dr. Bischoff formerly practiced in Cresco. Dr. Keith Hummel has left his Hartley Medical Clinic practice for practice in Virginia. Dr. Hummel had been at the clinic for eight months. Dr. Louis Katz, Davenport, has been awarded the John H. Sunderbruch Achievement Award for Excellence in Public Health. The award was given for Dr. Katz's "ongoing

dedication in the area of infectious disease, particularly AIDS prevention, education and public awareness." Dr. Steven Berry has been elected president of the Mercy Hospital Medical Center staff, Des Moines. Dr. Michael Disbro has been elected secretary/treasurer. Dr. Thomas Brown has been elected president of the Polk County Medical Society; Dr. Richard Gloor has been elected secretary/treasurer. Dr. Randall Alexander, associate professor of pediatrics at the U. of I. College of Medicine, has been named to the Board of Directors of the National Committee for Prevention of Child Abuse. Dr. Charles Marriott, retired Sioux City radiologist, recently received the 1992 Sertoma Club Service to Mankind Award. Dr. Michael Donohue and Dr. Lawrence Donovan, Spirit Lake, have been named fellows of the American Academy of Orthopaedic Surgeons. Dr. Sue Olmstead, formerly of Ankeny, has joined Dr. Lorn Matthews and Dr. Scott Honsey at Northwest Medical Clinic, Des Moines, Dr. Robert Roof has left Family Practice Associates in Manchester. Dr. Peter Buck, an orthopaedic surgeon at McFarland Clinic in Ames, has been elected to the Arthroscopy Association of North America. Dr. Ronald Everson has joined the Peoples Community Health Clinic, Waterloo. Dr. Everson received the M.D. degree from the U. of I. College of Medicine and completed a family practice residency at Iowa Lutheran Hospital, Des Moines.

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In the Public Interest

Ensuring efficient death investigation

Editors' note: This month's guest author is Peter Stephens, M.D. Dr. Stephens, a Cedar Rapids pathologist, is chairman of the IMS Forensic Medicine Committee.

N MOST CIVILIZATIONS THERE has been a pro-Lhibition against acts of physical violence outside limits established by community consensus. These have generally been confined to war, judicial retribution and religious rituals.

At first, non-physicians were appointed to investigate illegal violence and prosecute it where appropriate, often availing themselves of medical expertise to assist in their duties.

The increased complexity of society and the public health advances of the nineteenth century expanded the role of physicians, culminating in the nation's first medical examiner system in the latter part of the nineteenth cen-

Countless hours of service

The Iowa Medical Society and its members have traditionally provided expertise in this area. Since the enactment of the state's County Medical Examiner statute, Iowa physicians have provided countless hours of community service as county medical examiners.

Iowa's county medical examiners have comforted the bereaved, identified hazards to the living and assisted law enforcement. Their offices and patients have been inconvenienced, but they have been only marginally reimbursed for their time and costs. They have not been provided with the training and continuing education required to function in an increasingly sophisticated technological and legal environment.

In effect, the statute places substantial responsibility on the physician medical examiners but no longer provides adequate resources. As a result, advances in technology have combined with societal changes to create a void in death investigation in our communities.

IMS committee appointed

Composed of physicians interested in trauma, pathologists and county medical examiners, the IMS Forensic Medicine Committee was appointed two years ago to evaluate problem areas in death investigation and to offer recommendations. For example, a recommendation that the State Medical Examiner's office meet the standards for accreditation by the National Association of Medical Examiners has been adopted by the IMS House of Delegates.

The committee is mindful of the long standing IMS policy favoring a fully-funded, accredited, full-time State Medical Examiner Office and has suggested ways this might be accomplished. We feel the time has come to seek legislative solutions to address the lack of personnel and facilities dedicated to death investigation.

Violence is a major public health issue. Although decreases have occurred in some categories, most states, including Iowa, have seen increases in most aspects of violent injury. This trend is likely to continue. Without competent and impartial medical input, investigations are incomplete and the criminal and civil justice systems suffer. Incomplete or substandard death investigation also presents a public health problem since convictions of the innocent and acquittals of the guilty exact significant costs in morbidity and decreased life expectancy.

Our understanding of the pathology of poverty is much improved when the natural deaths of the poor and homeless outside of the health care system are properly investigated. Indeed, one must ask whether a society that lacks concern for the dead truly cares about the

living.

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†Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

#Verapamil should be administered cautiously to patients with impaired renal function

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BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see Warnings), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick simus syndrome (if no pasemaker is present), 2nd- or and dysgere AV block (if no pasemaker is present), artiel future/fibrillation with an accessory bypass tract (eg. WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe Ut dysfunction (eg. ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with avere degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is product. Some patients with paroxysmal and/or chronic cairful future/fibrillation and an accessory AV pathway (eg. WPW or LGL syndromes) have developed an increased antergrade conduction across the accessory pathway bypossing the AV node, producine a very rapid enaccessory are partnerly reg, virv. wor't CCL synauriesy have beenoped an increased anegated conduction across the accessory pathway bypassing the AV note, producing a very rapid ventricular response or ventricular fibrillation after receiving IV. venapamil for digitalist, Beautraindicated in such patients. AV block may occur (2nd and 3nd degree, 0.4%). Development of marked its degree block or progression to 2nd- or 3nd degree. Or 3nd and an admittance of appropriate control of the progression of a propriate degree block requires reduction in dosage or rarely discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were eated with verapamil

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function fin severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenné's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent veuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmis sion. Combined therapy with beta-adrenergic blockers and verapamil may result in additive soil. Commercial metally with detailed regulated and velopatin may resolut in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractibility, there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and proprianolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully References: 1. Data on file. Searle. 2. Edmonds D., Würth JP., Baumgart P., et al. Twenty-Four-hour monitoring of biod pressure during calcium antagonist therapy. In: Fleckenstein A. Largaf SH. eds. Hypertension—the Next Decade: Verapamil In Focus. New York, NY: Churchill Livingstone; 1987-94-100. 3. Midtibe Verapamil In Focus. New York, NY: Churchill Livingstone; 1987-94-100. 3. Midtibe D. A. Effects of Iong-term verapamil therapy on serum lipids and other metabolic parameters. Am J Cardol. 1990;66:131-151. 4. Fagher B. Henningsen N. Hulthén L., et al. Antihypertension. Eur J Clin Pharmacol. 1990;39(suppl. 1):541-543. 5. Schmieder Re, Messerii FH. Grarwaglia GE, et al. Cardiovascus 1991;39(4):541-543. 5. Schmieder Re, Messerii FH. Grarwaglia GE, et al. Cardiovascus of Iong-term verapamil in patients with essential hypertension. Circulation. 1997;79:1050-1056. 6. Middle N. Lauve O. Has O. No metabolic side effects of Iong-term 1036. 6. Midtba K, Lauve O, Hals O. No metabolic side effects of long-term treatment with verapamil in hypertension. *Anglology*. 1988;39:1025-1029.

monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flectanide and verapamil may have additive effects on myocardial contractifity. AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomypathy should be avoided, since significant hypotension may result. Concomitant use of fithium and verapamil may result in a lowering of the contraction of th serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be scalari mulari review an increases estimative to familiar. I activities to extend to consider the monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may antagonists needs careful thration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromiscular blocking agents (curra-file and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumongenic potential, and verapamil was not mutagenic in the Ames test. Preparaty Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only it clearly needed. Verapamil is excreted in breast milk, therefore, nursing ould be discontinued during verapamil us

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Do health care reform proposals overlook physician ethics? Page 252 Internal medicine . . . manpower concerns continue

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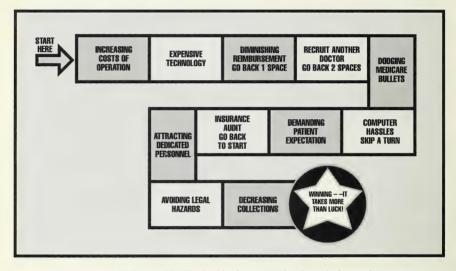
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- Bacterial meningitis: an 11-year review 263 Vaccination of more lowa infants is needed, say these

Stephen Rinderknecht, D.O., Lance Longnecker, M.D.

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William Eversmann, Jr., M.D.

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Few professions offer the variety of vocational activity of medicine. Physicians can be teachers, researchers, practitioners, reviewers, or administrators within the health care community.

Is it any wonder that such diversity can separate us even before we consider that medical practice can be primary care to specialty care or medical specialist to surgical specialist.

In many ways the diversity of medical practice has undermined the profession, weakening our unity in thought, practice and purpose. More recently the government and our critics have capitalized on our diversity and used it to destroy our commonality, weaken our unity and destroy our concord in medicine for even less than a few pieces of silver.

Surgeons have gone one way, internists another, family practice or pediatrics still another. Each group is focusing on its own perspective and often causing divergence rather than convergence, division rather than concurrence and multiplicity rather than unity.

This is a time when the medical profession cannot afford to be divided. Collective action by medicine is necessary. Uniformity in action, wholeness of purpose, singleness of practice and convergence of thought must be achieved.

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The Editor Comments



Marion E. Alberts, M.D.

Mourning the "three Rs"

Everything rises but to fall and increases but to decay.

> —Sallust, Jugurtha Roman Historian (86-34 BC)

BELIEVE WE SHOULD BE more concerned Labout preparing our children for their place in society. True, our society becomes more complex each year, but values of years past must be preserved. I am concerned about education in the early years of school as it pertains to the basics of reading, writing and arithmetic. Too much emphasis is placed on making everything easier at the expense of understanding basic principles. I have observed some instances in my children's education which prepared them poorly for their future needs. Now I am noting more "innovations."

Computers, calculators and the lack of writing skills have taken their toll. The concepts of making education easier are fallacious. Learning the basic laws of arithmetic, spelling, sentence structure and readable penmanship is not an easy task, nor should it be made easier for the sake of expediency. In the early years of education there is so much to be taught and learned that much of the embellishment must be postponed until the basics are mastered.

I have a nephew who learned to read symbols instead of our usual basic words. I had a receptionist who could not write

cursive-not even her signature. My oldest son was taught similarly, but overcame the situation by writing a combination printed letter/cursive hand. Now there is a new concept to "avoid stress" on the child . . . simplified spelling where words are spelled in any fashion that suits the child . . . no rules of right or wrong. Coupled with this, new typewriters and word processors have built-in mechanisms to indicate correct spelling and grammar.

Sentence diagraming is out ("a waste of time and effort"); yet that outmoded concept certainly instilled a feeling for correct sentence structure. The essay-type examination has been replaced by the computer generated and evaluated "fill in the correct answer symbol with a no. 2 pencil" examination form. Teachers are not required to grade papers and the students are not required to apply constructive reasoning to solve problems presented to them. Where is the savings when students emerge from school ill-prepared to meet life's challenges?

It has been shown that a majority of students in our country lack many basic academic skills, as well as languages, geography and history. I fear the next generation will demonstrate a weakness in their abilities. They maybe adept in a narrow range but totally ill-equipped in general knowledge. Is that advancement? . . . toward decadence per-

Medical ethics and health care reform

Are physicians' ethical responsibilities being ignored in the rush to make health care into a business? This author, a gastroenterologist practicing in Des Moines, thinks so.

Jon Gibson, M.D.

Des Moines, Iowa

This year marks the centennial of publication of *The Principles and Practice of Medicine*, which William Osler wrote in preparation for establishment of the Johns Hopkins University School of Medicine. He and his colleagues demonstrated that medical science and ethics, firmly grounded in ancient, wisdom, could transform our health care system into an enduring model for progress.

Nineteen ninety-two has also produced initiatives for health care reforms, but it is important to ask whether these proposals will be validated by meaningful and lasting contributions to medicine and public policy. In Iowa, health care policy changes have been proposed by the Health Policy Corporation of Iowa (HPCI) in its "Iowa Health Providers Guide," and by the Iowa Leadership Consortium (ILC) on Health Care in its document "Health Care Reform: A Discussion Paper for Iowans." Both reform proposals ignore the role of medical ethics.

There is a covenant between society and the medical profession which demands that physicians act ethically and society respect these ethics. If reforms in Iowa's health care system are to be effective and durable, if they are to properly motivate physicians, they must respect the profession's ethical precepts.

Medicine and public policy

The history of public policy and the profession extends from ancient times. Nearly 4,000 years ago, Hammurabi devised an elaborate code to govern those who practiced medicine and surgery.

Current public policy initiatives in Iowa seek consensus for reform—one hopes for effective and durable reform. The ILC proposal suggests the need for organized delivery systems that would compete against a target level of expenditures and which "must be linked by some administrative entity, and must be capable for accepting and managing capitated payment." The HPCI advises:

integrated systems that involve a cooperative or collaborative effort between physicians, nurses pharmacists, hospitals, and other providers [which] should provide opportunities to lower costs, improve outcomes, and make services more convenient for the consumer.²

These are business models which are in direct conflict with ethical medical practice. The American College of Physicians (ACP) Ethics Manual stipulates:

Third party agreements: physicians' ethical responsibilities

In response to a policy resolution introduced during last year's House of Delegates sessions, the House has requested that IMS members be encouraged to "consider the ethical implications of signing agreements with third party payors."

In its 1992 Code of Medical Ethics — Current Opinions, the AMA's Council on Ethical and Judicial Affairs included a section on physician contracts. The council's

opinion is reprinted here.

Referral of patients—disclosure of limitations. When a physician agrees to provide treatment, he or she thereby enters into a contractual relationship and assumes an ethical obligation to treat the patient to the best of his or her ability. PPO and HMO contracts generally restrict the participating physician's scope of referral to medical specialists, diag-

nostic laboratories, and hospitals that have contractual arrangements with the PPO and HMO. Some plans also restrict the circumstances under which referrals may be made to contracting medical specialists. If the PPO or HMO does not permit referral to a noncontracting medical specialist or to a diagnostic or treatment facility when the physician believes that the patient's condition requires such services, the physician should so inform the patient so that the patient may decide whether to accept the outside referral at his or her own expense or confine herself or himself to services available within the PPO or HMO. In determining whether treatment or diagnosis requires referral to outside speciality services, the physician should be guided by standards of good medical practice. (II, VI)

The physician should avoid any business arrangement that might, because of personal gain, influence his decision in patient care. Activities of physicians relating to the business aspects of his own or his group's practice should be guided by the principle that such activities be intended for the reasonable support of that practice and for the effective provision of quality care for patients.³

It is not likely the motivation of a CEO managing a business would be that of a physician attending a patient.

Professional ethics, ideals

The medical profession's priorities are born of the science of moral duty and human ideals. Ancient and cherished oaths elevate care of the sick to medicine's highest aspiration. Modern ethical teachings reiterate this professional duty. Osler counselled, "To prevent disease, to relieve suffering, and to heal the sick—this is our work."

There is a contract or covenant between society and the profession, and in response to

the franchise granted them, physicians carry certain fiduciary responsibilities. The medical profession must ensure competence of its practitioners and foster compassion and confidentiality in physicians. The attending physician accepts ultimate responsibility for the care of the patient. Competent medical services must be available to all patients, regardless of ability to pay. Finally, "The physician must avoid any personal commercial conflict of interest that might compromise his loyalty and treatment of patients."

In turn, society is obliged to respect medical ethics. It seems likely that erosion of ethical principles explains much of the disenchantment now prevalent among physicians. Society should grant physicians a standard of living which will allow them to perform their services "with liberty of mind, health of body, and to adequately fulfill family and social obligations."

(Continued next page)

Where government requires licensure for physicians, it recognizes that medical care is not a commercial enterprise in which the buyer must beware. As Osler said, "The practice of medicine is an art, not a trade; a calling, not a business."4

Beware of hasty initiatives

There is no new thing under the sun. Public policy regarding medical practice and the traditions of the profession's ethical ideals have a long history and their time-honored lessons must not be lost in hasty initiatives to reduce costs. It is not the purpose of this paper to deter the conscientious search for solutions to an acknowledged crisis, but only to emphasize the importance of ethical principles to any lasting solution. The contract between society and the medical profession must recognize appropriate priorities and avoid incentives for physicians to act as businessmen.

The physician should lend expertise to the development of health policy. That the medical profession's ideals have not always overcome human greed or minimized human suffering does not invalidate the wisdom of an idealistic ethic. Osler also articulated this nearly a century ago:

Not that we all live up to the highest ideals, far from it-we are only men. But we have ideals, which means much, and they are realizable, which means more.

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Internal medicine manpower in Iowa

There is growing concern over the supply of general internists say these authors, who are both affiliated with the University of Iowa College of Medicine.

John Fieselmann, M.D. Janet Schlechte, M.D.

Iowa City, Iowa

BETWEEN 1965 AND 1990 THE NUMBER of internal medicine specialists in the U.S. rose from 37,780 to over 98,000. Some subspecialties grew at an even faster rate.

It is important to understand how changes such as managed care, a shift from inpatient to outpatient visits and changes in payment systems have affected Iowa internists.

General internal medicine

Internal medicine is the second largest medical specialty in Iowa (16.8% compared to 27.8% for family practice). As of February 1992, 657 Iowa physicians characterize themselves as specialists in internal medicine (Table 1). Forty-two percent of all internists characterize their practice as primarily general internal medicine. Of these, 237 have an M.D. degree and 38 are Doctors of Osteopathy.

Iowa generalists are young — fewer than 25% are over age 50 and 40% are between 30-39 years. Seventy-two Iowa internists are female comprising 14.5% of the generalists. In contrast 18.5% of generalists nationwide are female.¹

There is at least one internist in 40 Iowa counties, but most are concentrated in areas of high population density. The internists in Polk, Dubuque, Black Hawk and Johnson counties comprise 50% of the total; 86% of all general internists reside in counties with

TABLE 1
IOWA PHYSICIANS BY SPECIALTY AND GENDER

Total	Male	Female
275	235	40
12	8	4
117	110	7
17	13	4
55	55	0
52	49	3
24	19	5
29	25	4
51	50	1
25	21	4
657	585	72
	275 12 117 17 55 52 24 29 51 25	275 235 12 8 117 110 17 15 55 55 52 49 24 19 29 25 51 50 25 21

populations that exceed 40,000. Thirteen smaller counties are served by only one general internist.

Internal medicine subspecialties

There are 382 internal medicine subspecialists in Iowa, accounting for 58% of the total internal medicine group. The subspecialists in private practice are found predominantly in 12 counties with populations ranging from 46,203 to 303,170. The 382 subspecialists include 147 physicians at University of Iowa in Iowa City.

In private practice, the largest subspecialties are cardiology (35%), gastroenterology (17%), hematology-oncology (16%) and pulmonary (12%). Eight percent of Iowa subspecialists are female ranging from 33% in allergy to 1% in pulmonary and 0% in gastroenterology (Table 1).

(Continued next page)

The Council on Graduate Medical Education has concluded there is an over supply of physicians.³ The number of physicians graduating from medical school is declining slightly but there is a consistent increase in the ratio of physicians to population.4

While the relative over supply of physicians may be controversial, there is little argument that the number of primary care physicians is declining. In remarks prepared for the Physicians Payment Review Commission, Dr. Robert Petersdorf of the American Association of Medical Colleges estimated that only 39% of U.S. physicians are primary care

physicians.4

The number of internists in Iowa increased from 331 in 1978 to 657 in 1992. The increase has occurred in both the generalist and subspecialty pools with 40% and 185% increases respectively. The marked increase in the number of subspecialists has changed the ratio of generalists to subspecialists from 60% in 1978 to 42% in 1992 mirroring the national trend toward specialization.1

The ratio of total internists to Iowa population has changed from 1:8761 in 1978 to 1:4226 in 1992. Over the same time frame, the ratio of general internists changed from 1:14,720 to 1:11,197. The optimal general internist/population ratio is not known. In 1981, the American College of Physicians cautioned against using physician-to-population ratios because of limited data regarding local variability.5 This is particularly true in Iowa since family practice physicians play a major role in the delivery of primary care.

From January 1989 through December 1991, 87 general internists entered practice in Iowa. Data supplied by the Office of Community-Based Programs in the College of Medicine at the University of Iowa reveals that 71% have an M.D. degree, 16 are Doctors of Osteopathy and 30% are female. Eighty percent are less than 40 years of age. Seventeen completed medical school at the U. of I. College of Medicine and 12 received degrees at the University of Osteopathic Medicine and Health Sciences in Des Moines. Fifty-one of the 87 (59%) completed their residency training in the Midwest, suggesting that graduates from midwestern training programs are a major source of new internists.

There is concern nationally that many general internists are choosing early retirement due to the frustrations of practice.⁶ For-

TABLE 2 REPORTED REASONS FOR DEPARTURE FROM PRACTICE IN IOWA 1989-1991

	Generalists	Subspecialists
Retirement	22	6
Death	2	2
Change of state	23	36
Further training	3	2
Other	5	6
Armed forces	1	
	56	52

tunately, this appears not to be the case in Iowa as the average age at retirement here was 69 years. Table 2 lists reasons internists gave for leaving practice in Iowa.² For general internists, 39% retired and 41% relocated. There is less information available for subspecialists but 69% indicated a desire to relocate as the reason for departure.

Over the last five years fewer students are entering categorical internal medicine residencies.7 Despite declining numbers nationally, Iowa internal medicine residency programs remain strong. In Iowa, residency training is available at U. of I. Hospitals and Clinics in Iowa City, Iowa Methodist Medical Center-Veterans Administration Hospital in Des Moines, and at the Des Moines General Osteopathic Hospital. Since 1986 224 internists have completed three-year training programs. Twenty-seven percent chose careers in general medicine and 10% selected Iowa as their practice site.

An analysis of the 87 new general internists in Iowa based on data provided by the Office of Community-Based Programs suggests that site of medical school training is the best predictor for choosing a practice in Iowa. Only five physicians without an Iowa medical school affiliation completed a residency in Iowa and stayed in Iowa to practice.

If this limited data is predictive, medical school graduates from the U. of I. College of Medicine or the University of Oseopathic Medicine and Health Sciences who select an Iowa or other midwestern residency program are the best candidates to meet primary care internal medicine needs in Iowa.

Conclusion

Despite the recent decline in U.S. graduates entering internal medicine, the number of internists locating in Iowa continues to grow

slowly. When compared to the flat population growth noted from the 1980 and 1990 census, Iowa has an improving physician-topopulation ratio. Unfortunately, the largest increase has occurred in the subspecialties. The number of general internists has only grown by 2-3% per year.

Assuming no sudden change in the number of physicians relocating or retiring, the Office of Community-Based Programs predicts there will be 325 generalists in Iowa

by the year 2000.

We can only speculate on how a declining number of primary care physicians will affect Iowa. Even if the number of general internists increases slowly, the total number of primary care physicians in Iowa may decline since a significant proportion of primary care is delivered by physicians other than internists. This is particularly relevant in family practice since a large number of those physicians are nearing retirement.8

Many national organizations support the expansion of primary care training in internal medicine. To encourage this support, several midwestern states are developing creative initiatives to enhance the attractiveness of primary care medicine. Hopefully, medical students will respond to efforts like these by selecting internal medicine for further training. For residents already in training, these initiatives may encourage careers in general internal medicine.

With increasing numbers of general internists, Iowa could improve its physician-topopulation ratio, particularly in primary care. If recent trends continue, this increase is likely to come from more female internists and individuals with medical school ties to Iowa or ties to the Midwest through residency training.

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IOWA MEDICINE Interview



Janet Schlechte, M.D.

Internal medicine: concern over supply continues

The governor of the Iowa Chapter of the American College of Physicians discusses the goals of that organization and developments in internal medicine.

What is the current picture with regard to the supply of internists?

The total number of internists is increasing. There is, however, a greater increase in the number of physicians entering procedurally oriented subspecialties of internal medicine such as gastroenterology, pulmonary medicine and cardiology.

What recent technological and scientific advances have affected your specialty?

The subspecialties of internal medicine are using new techniques to develop procedures and tests to improve diagnostic accuracy. The general internists may be more affected by the changes occurring in preventive care, i.e., cholesterol screening, mammography, etc.

All aspects of internal medicine will clearly be affected by the continuing advances in molecular biology.

What socioeconomic developments have influenced internal medicine?

The development of managed care systems and the lack of affordable health care for many Iowans are probably the most important recent socioeconomic developments.

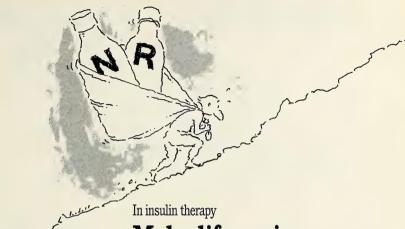
What are the concerns and goals of the American College of Physicians, Iowa Chapter?

The mission of the American College of Physicians is to enhance the quality and effectiveness of health care by fostering excellence and professionalism in medical practice.

The Iowa Chapter strives to promote the highest clinical standards and ethical ideals, serve the professional needs of our members, serve as an information resource for Iowa internists and advance internal medicine as a career.

What developments in the field of internal medicine most interest you personally?

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Peripheral vascular disease

Peripheral vascular disease and coronary artery disease coexist. Practicing physicians need to be aware of the signs, symptoms and treatment available to this group of patients. Lifestyle modifications can help decrease morbidity and mortality in these patients.

L. A. Iannone, M.D. Koreen LeMaster Rayl, R.N.

Des Moines, Iowa

A THEROSCLEROTIC DISEASE RARELY OCCURS at only one site. Many authors have documented that peripheral vascular disease and coronary artery disease coexist. 1-6 Research studies continue to reinforce this theory. Since atherosclerosis is the same disease process that causes both coronary and peripheral vascular disease (PVD), this contention will become more apparent.

Cardiologists need to be aware of the prevalence of coexisting PVD, including renal artery stenosis (RAS). The family physician needs to be concerned with the early signs, symptoms and treatment of the disease process. We also need to be aware of symptoms that may mask other diseases. Patients who live sedentary lifestyles, because of limiting claudication factors, may have silent myocardial ischemia.¹

Dr. Iannone practices internal medicine in Des Moines. He specializes in cardiovascular diseases. Ms. Rayl practices with Dr. Iannone.

Attention should be paid to the coexistence of coronary artery disease (CAD) and PVD. The National Health Interview Survey of 1982 estimated over 2.9 million Americans had "hardening of the arteries," which reflects the prevalence of PVD in the general population.

Bachman et al, performed "total body angiography" in patients with coronary disease to help identify the candidates at risk for generalized atherosclerosis. Of 2,432 patients with angiographically documented coronary heart disease, 63.8% demonstrated an overall incidence of PVD. The presence and severity of PVD correlates with the severity of CAD. Of the 2,432 documented cases, two-thirds have generalized atherosclerosis and one-third have CAD exclusively.²

It has been documented that myocardial infarction is the cause of death in approximately half of all postoperative deaths occurring after abdominal or lower extremity revascularization. Fig. Since 1978, all patients under serious consideration for elective vascular reconstruction at the Cleveland Clinic are advised to undergo preoperative coronary angiography. Hertzer reported on 95% of the 273

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patients who underwent lower extremity revascularization between 1969-73.

Fatal myocardial infarction (MI) was responsible for 52% of postoperative deaths in the entire series. In this same series, complications of CAD caused 50 and 55% of all the deaths occurring five to 11 years postop. In patients without preoperative evidence of CAD, MI accounted for 60% of the late deaths. Of the patients suspected to have CAD, MI accounted for 31/59, 52% of the late deaths.³

Tomatis *et al* reported severe CAD in 47% of their patients with aortoiliac disease, 48% with femoropopliteal disease and 75% in a selected series of abdominal aortic aneurysm.¹² Jamieson *et al* conducted a study to determine the influence of CAD on early and late mortal-

'The family physician needs to be concerned with the early signs, symptoms and treatment of the disease process. We also need to be aware of symptoms that may mask other diseases.'

ity rates after peripheral vascular or abdominal aortic reconstructive surgery (161 pts). Thirty day mortality rate was 6.7% for abdominal aortic surgery, 3.4%—aortoiliac and 1.4%— femoropopliteal surgery. Early postoperative death caused by MI was due to coronary artery disease.⁴

As stated in the Whitehall study, patients with intermittent claudication have a twofold increase in age-specific risk of death and a loss of 10 years in life expectancy. Cardiovascular disease accounts for most or all of this increased mortality.⁶

The Framingham study demonstrated that hypertension is a major risk factor for the development of CAD. Various authors have performed abdominal aortogram on patients undergoing coronary angiograms (with or without hypertension) to document the incidence of RAS. Harding identified renal artery disease in 325/1015 — 32%. Significant disease (defined as ≥50%) was found in 158 — 16% of the patients, 126 — 80% had CAD and 10% were without coronary disease.8

Patients with coronary artery disease and hypertension have a high incidence of RAS. Renal failure secondary to ace inhibitors may occur in patients with bilateral RAS. Renal artery stenosis is a fairly new subject of discussion and the incidence is unknown; however, the prevalence of CAD and RAS is well documented.^{8,9} Choudhri *et al* examined 100 patients undergoing peripheral angiogram who also had renal digital subtraction to identify the incidence of RAS in patients with CAD. Bilateral RAS was found in 24/100 — 24% of the patients.⁹

Early identification of PVD

Patients at risk for the development of PVD need to be identified early in the disease stage when lifestyle modifications can help slow its progression. The interventions available in treating hemodynamically significant PVD should only be done to help increase the patient's quality of life unless a patient is at risk of losing a limb.

The Framingham study found that within 10 years after the initial diagnosis of PVD, 40% of the patients died. Men who had developed intermittent claudication had an annual mortality which averaged 39/1000 as compared to 10 deaths per 1,000 men free of the affliction.⁷

The early identification of RAS can help preserve renal function and prevent kidney damage. Schreiber *et al* found that 39% of RAS became completely occluded, losing the function of that kidney, on an average of 13 months following an initial stenosis of 75 — 99%. ¹⁰ Meaney *et al* substantiate this data. ¹¹

Conclusion

As practicing physicians, we need to keep abreast of new information in the medical treatment of various disease processes. This review of literature shows the high incidence of PVD in cardiovascular patients and vice versa. Identifying these patients at risk early in the disease process will help decrease morbidity and morality. Peripheral vascular symptoms such as claudication may mask symptoms of CAD (silent myocardial ischemia). Angioplasty or peripheral vascular surgery for atherosclerotic lesions in the iliac or lower extremities will increase the patient's ability to exercise and quality of life.

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References noted are available from the authors or the editors of IOWA MEDICINE.

Bacterial meningitis: an 11-year review

The authors discuss a study which illustrates the need for vaccination of lowa infants against bacterial meningitis.

Stephen Rinderknecht, D.O.

Dallas, Texas

Lance Longnecker, M.D.

Des Moines, Iowa

BACTERIAL MENINGITIS is a significant cause of morbidity and mortality in pediatrics. The epidemiology and clinical aspects of the disease are well established.^{1,2} As antibiotic resistance develops and immunization advances take place, the need for continued surveillance is obvious.

This paper highlights the epidemiologic, clinical and laboratory findings in 189 central Iowa children with bacterial meningitis. Since the conclusion of this study, vaccination of young infants against *Haemophilus influenzae type b*, the most frequent cause of childhood meningitis, has become routine. The currently used vaccine for *H. influenzae type b* may have a significant impact on the incidence of infant and childhood meningitis. The results of this study have established a baseline for comparison during the upcoming immunization era.

Methods

We performed an 11-year review of 189 patients over 30 days old with bacterial meningitis admitted to Raymond Blank Memorial Hospital for Children in Des Moines, Iowa. The study period was from January 1, 1980 through December 31, 1990. Yearly admissions were consistent during the study.

Meningitis was defined as a positive bacterial culture of the cerebrospinal fluid (CSF) or CSF pleocytosis with either a positive agglutination test or gram stain on the CSF. Any child with an intracranial foreign body was excluded.

Charts were reviewed for history of upper respiratory tract symptoms, vomiting or seizures prior to admission. Initial examination findings of otitis media (unilateral or bilateral), nuchal rigidity and abnormal fontanel were noted. A fontanel described as "bulging" or "full" was considered as abnormal.

Initial laboratory analysis was performed by a certified clinical laboratory. The analyses reported were the initial tests performed when the patient presented for medical care. CSF and blood samples were cultured on routine medium. Latex agglutination testing (Wellcome Diagnostics, Dartford, England) for *H. influenzae, Streptococcus pneumonia* and *Neisseria meningitidis* was performed on many CSF samples. A chromogenic method using Nitrocefin (BBL Microbiological Systems, Cockeysville, Maryland) was used to determine beta-lactamase production in *H. influenzae* isolates.

Duration of initial fever was recorded from the time of admission until the patient's temperature was less than 100°F and remained there for at least 24 hours. "Previous antibiotic" is defined as any type of antibiotic given prior to obtaining blood and CSF cultures.

Evidence of complications during the hospitalization were extracted from the patient charts and defined as follows:

Death—mortality directly related to meningitis.

(Continued next page)

Dr. Rinderknecht, formerly of Des Moines, is a pediatrician with the University of Texas Southwestern Medical School Department of Pediatrics. Dr. Longnecker is in the private practice of pediatrics in Des Moines.

Seizure—any clinical evidence of seizure activity.

Syndrome of inappropriate ADH secretion (SIADH) — hyponatremia and its correction after fluid restriction.

Abnormal computerized axial tomography (CAT) scan—any abnormal finding per reviewing radiologist.

Deafness—audiometric testing consistent with severe bilateral hearing loss.

Neurologic sequelae—evidence of non preexisting motor or CNS compromise at the time of discharge.

Results

The major pathogens isolated included *H. influenzae* (73%), *S. pneumonia* (13%) and *N. meningitidis* (9%). The less frequently occurring isolates (5% of the cases) were usually associated with risk factors.

The incidence of meningitis was quite stable at 17.2 cases per year until 1990 when only seven cases occurred. 1990 was also the first year in which *H. influenzae* was responsible for less than 50% of the total cases. The frequency of beta-lactamase producing *H. influenzae* increased throughout the study period. No isolates produced beta-lactamase in 1980, but 41% were beta-lactamase producing during the past five years.

The male to female ratio was 1.5:1.0; fewer cases were seen during the summer months. The age distribution for *H. influenzae* meningitis displays a peak incidence between 7 and 12 months of age. Three patients, however, were over five years of age. Age distribution for *S. pneumonia* and *N. meningitidis* was more sporadic, but both occurred in young infants less than six months of age and in older children greater than five years of age.

The average duration of illness prior to admission was 2.6 days. Major symptoms at the time of admission included vomiting (62%), upper respiratory tract symptoms (41%), and seizure activity (13%). Major signs included otitis media (31%), nuchal rigidity (84% when greater than or equal to 12 months of age and 60% when less than 12 months of age), and abnormal anterior fontanel (55% when less than 12 months of age).

A comparison was made in the laboratory evaluation of the CSF between the three leading etiologic agents (Table 1). A comparison was also made of the hematologic analyses of these patients (Table 2). Of note is the signifi-

cant leukocytosis produced by *S. pneumonia* and the relatively constant, elevated, band to total neutrophil ratio among all three etiologies

Latex agglutination testing was performed on the CSF in 118 cases of *H. influenzae*, 9 cases of *S. pneumonia*, and 6 cases of *N. meningitidis*. The sensitivity of the testing was 91%, 55% and 0% respectively. The gram staining of CSF had an overall sensitivity of 85% for the identification of bacteria. The gram stain sensitivity for *H. influenzae*, *S. pneumonia*, *N. meningitidis* was 90%, 88% and 37% respectively.

A positive blood culture was obtained in 88% of all cases when no previous antibiotic was used (n=101). This decreased to 71% when a previous antibiotic was given (n=63).

The use of a cephalosporin for empiric therapy has increased since 1986. It was used in 57% of cases in 1990. The administration of dexamethasone at the start of therapy has gained rapid acceptance since 1987. It was used in 86% of cases in 1990. Dexamethasone was used in 26 patients. No patients received the steroid prior to the initial antibiotic dose. The initial dose of dexamethasone was administered from five minutes to four hours after starting antibiotics. The average duration of initial fever without dexamethasone (N=148) and with dexamethasone (N=26) was 64 and 16 hours respectively.

A CAT scan was performed in 51 cases (31%), and was abnormal in 23 of these cases. The most frequent reasons cited for CAT scan evaluation included: prolonged fever in 18 cases, seizures in 15 cases and recurrent disease in three cases.

The incidence of several immediate complications are shown in Table 3. The total death rate was 4%. *S. pneumonia* was associated with the highest rate of each complication, including severe hearing loss in 28%.

Conclusions

Bacterial meningitis causes significant morbidity and mortality in pediatrics. This disease resulted in one of every 200 admissions to Blank Children's Hospital. For these reasons meningitis needs to be well understood by all who are involved in the care of children. *H. influenzae, S. pneumonia,* and *N. meningitidis* were the etiologic agents in 95% of all cases. With the exception of a single case of viridans streptococcal meningitis, the remaining causative organisms were all associated with high risk patients.

TABLE 1
SPINAL FLUID ANALYSIS

	H. influenzae	S. pneumonia	N. meningitidis
WBC/mm ³ ×10 ³	6.4 ± 3.5	2.2 ± 2.7	3.6 ± 4.8
% Neutrophils	86 ± 87	80 ± 26	78 ± 32
Protein (mg/dl)	163 ± 61	245 ± 193	169 ± 129
Glucose (mg/dl)	31 ± 27	36 ± 35	47 ± 35
Glucose CSF/Glucose Serum	0.25 ± .22	0.26 ± .06	0.34 ± .21

Mean + 1 S.D.

TABLE 2
HEMATOLOGIC ANALYSIS

	H. influenzae	S. pneumonia	N. meningitidis
WBC/mm ³ ×10 ³	13.9 ± 8.9	22.6 ± 2.7	18.1 ± 15.3
Absolute Neutrophil Ct × 10 ³	6.8 ± 8.5	13.3 ± 10.2	12.6 ± 13.2
Absolute Band Ct × 10 ³	2.8 ± 2.6	4.6 ± 3.5	2.1 ± 1.5
Band/Total Neut Ratio	0.33 ± 0.19	0.32 ± 0.26	0.23 ± 0.21

Mean ± 1 S.D.

TABLE 3

COMPLICATIONS DURING HOSPITALIZATION OR AT TIME OF DISCHARGE (PERCENTAGE)

	H. influenzae N=138	S. pneumonia N=25	N. meningitidis N=17	TTL
				,,,
Death	5 (4)	2 (8)	1 (6)	8 (4)
Seizure	15 (11)	7 (28)	1 (6)	23 (13)
SIADH	10 (7)	4 (16)	1 (6)	15 (8)
Abn. CAT	17 (12)	3 (12)	0 (0)	20 (11)
Deafness	3 (2)	7 (28)	2 (12)	12 (7)
Neurologic Sequelae	6 (4)	2 (8)	1 (6)	9 (5)

Neonatal pathogens must be considered when meningitis occurs during the second and third months of life; four cases greater than 30 days were caused by either *Streptococcus agalactiae* or *Escherichia coli*.

The epidemiologic factors considered were consistent with previous reviews.^{1,2}

Ampicillin resistance among *H. influenzae* was first described in 1974.³ Beta-lactamase producing *H. influenzae* is a growing concern for central Iowa. No isolates produced beta-lactamase in 1980, while 41% produced this enzyme in 1986 though 1990. *H. influenzae type b* is the primary cause of meningitis and the primary pathogen in epiglottitis, septic arthritis (less than two years of age) and facial cellulitis. It is a significant pulmonary pathogen. Knowl-

edge of geographic trends in beta-lactamase production is important when deciding on empiric therapy for invasive *H. influenzae* diseases.

The poor sensitivity of latex agglutination testing on CSF in this review is hard to explain. Unlike fluorescent antibody techniques, latex agglutination testing does not require tremendous technical skill in performing the test or interpretation of the results and the poor sensitivity may simply be intrinsic to the test. The rapid assay for beta-lactamase involves the use of a chromogenic cephalosporin which changes color upon hydrolysis of its beta-lactam bond. Although rare, beta-lactamase negative, ampicillin resistant strains have been isolated in childhood meningitis. Latex agglutination

(Continued next page)

testing of CSF and rapid beta-lactamase testing of isolated organisms should be used as a supplement to, not a replacement for, conventional

culture and susceptibility testing.

Third generation cephalosporins, cefotaxime and ceftriaxone are now frequently used as empiric therapy. Their efficacy is well established and their margin of safety is much greater than that of chloramphenicol. Despite having new agents and rapid sterilization of CSF, the sequelae and mortality rate in childhood meningitis remain the same.⁵

Dexamethasone therapy has been shown to significantly decrease neurologic sequelae. particularly hearing loss.6 It was used in nearly 90% of all cases over the past two years. Its mechanism of action as a potent inhibitor of inflammation is better understood due to recent advances in understanding the pathophysiology of bacterial meningitis and the important role of the host's inflammatory response.7

Late onset morbidity was not evaluated. Complications during the hospital stay were more likely to occur with S. pneumonia than with other organisms. An overall fatality rate of 4% is similar to other published data. Because dexamethasone was used in relatively few cases its impact on these immediate complica-

tions was not pursued.

In summary, H. influenzae has been the leading cause of childhood meningitis (73%). With good compliance from health care professionals, this age group will now be immunized and a drastic reduction in the incidence of meningitis is predicted. The frequency of beta-lactamase production in H. influenzae type b is a growing concern for central Iowa. S. pneumonia is the most likely pathogen to result in immediate complications during childhood meningitis.

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More ethical CME

Richard Nelson, M.D.

IN THE MARCH ISSUE of *The Atlantic Monthly,* Dr. Arnold Relman expressed his concern that the medical profession has lost its ethical way. This distinguished former editor-inchief of The New England Journal of Medicine mused about the crumbling contract between society and the profession. In his view this contract awards physicians a privileged position, based upon the expectation that the dominant motivation of a physician's care is service to patients and not monetary gain.

He concludes that the commercialization of health care—including CME—now threatens the objectivity of medical decision-mak-

ing:

... drug manufacturers offer inducements to practicing physicians to attend seminars at which their products are touted, and even to institute treatment with a particular drug. In the former case this ostensible justification is furtherance of post-graduate education; in the latter it is the gathering of postmarketing information about a new drug. The embarrassing transparency of these subterfuges has recently caused pharmaceutical manufacturers to agree with the AMA that such practices should be curtailed.

Dr. Relman's convictions have been shared by the bodies accrediting the sponsors of continuing medical education programs. The Accreditation Council on Continuing Medical Education has developed guidelines to assure ethical practices in the development, support and conduct of CME activities.

Concern about potential Food and Drug Administration (FDA) involvement in this issue has prompted pharmaceutical manufacturers to reconsider support of CME provided by universities, hospitals and medical specialty societies. The major venue of that support is an educational grant to CME sponsors that underwrites a portion of the costs of programs. The sponsor retains full responsibility for the content of the program. Such support is appropriate.

This controversy is a healthy development in continuing medical education, which must be more participant, rather than sponsor, driven. In our experience at the U. of I. the CME courses which most consistently receive high marks from participants are those whose content addresses the practice needs

of community physicians.

Continuing education, like medical practice, requires a contract between the educator and the learner. The contract is founded upon trust and mutual respect. The trust derives from an understanding that the knowledge being shared is unbiased and objective. Mutual respect occurs when the educator and learner recognize the contribution of the other in improving medical care. Throughout the most creative continuing medical education events there is an intermittent reversal in the educator and learner roles. The faculty and participants can function in either capac-

As physicians we enjoy a priviledged place at society's table. That place is granted to us not based upon entrepreneurial skill, but upon our commitment to placing the welfare of our patients first on the professional agenda. We acquired our clinical skills for that purpose; so must we maintain them.

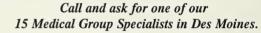
Dr. Nelson is associate dean for continuing medical education at the University of Iowa College of Medicine.

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Respiratory distress

Note: The Iowa Foundation for Medical Care (IFMC) reviews care of Medicare beneficiaries in hospital outpatient and ambulatory surgery centers. Physician reviewers look for care that meets acceptable standards and complete documentation.

A 68-YEAR-OLD MALE WITH a history of chronic obstructive pulmonary disease (COPD) was admitted with progressive shortness of breath and weakness. Arterial blood gases on admission were pCO2 of 60 and pO2 of 39 on room air. The patient was placed on O2 at 2-3 liters per nasal cannula. There was no follow up of the arterial blood gases until 10 days later when the patient deteriorated and had a respiratory arrest requiring intubation.

The patient's anxiety increased the day before his respiratory arrest. The nurses' notes indicate the patient was anxious and experiencing dyspnea and tachypnea—up to 40/minute per graphic sheet. The patient received Xanax for his anxiety and was allowed to smoke while under treatment for severe COPD. The patient died in the hospital 16 days after being admitted.

Reviewer comments

In a patient with severe COPD, arterial blood gases should have been repeated after oxygen therapy was initiated. Further adjustment in oxygen therapy could be made as indicated based on follow-up arterial blood gas results. No additional blood gases were obtained after admission until the patient's condition deteriorated 10 days later.

Repeat of arterial blood gases, chest xray and complete blood count are indicated to evaluate the anxiety in this patient with severe COPD. Pulse oximetry gives an estimation of pO2 only and may give a false sense of security in evaluating a patient with CO2 retention. A medication with respiratory depressant properties is inappropriate until one is certain this will not have adverse effects on the patient, or if comfort care for a terminally ill patient is being provided and documented.

Based on the severity of COPD, an order permitting the patient to smoke should not have been given.

The physician's progress notes were incomplete. No elaboration of the patient's condition or plan of care were recorded. Progress notes should describe the patient's status and the plan of therapy.

According to the HCFA guidelines, this is a quality concern with an assigned severity level II: confirmed quality problem with the potential for significant adverse effects on the patient.

The patient's condition deteriorated on the ninth and tenth days after admission with increasing shortness of breath and dusky color. The progress notes indicated only that the respiratory distress continued. On the ninth day after admission, the physician was contacted regarding the patient's change in condition (confusion, shortness of breath and anxiety). The physician prescribed Xanax over the phone.

The patient's agitation was most likely due to increased hypoxemia. Repeat arterial blood gases, chest x-ray and complete blood count were indicated to evaluate the respiratory status of the patient. Xanax or any other sedative/hypnotic with depressant properties was inappropriate for this patient.

This article was written by Gregory Hicklin, M.D., a Des Moines internist specializing in pulmonary diseases.

Clinical preventive services guide available

THE BENEFITS OF INCORPORATING prevention a live tion, a key component of the health care continuum, into medical practice have become increasingly apparent. During the past 30 years, common conditions have declined in incidence following the introduction of ef-

fective immunization or screening.

Although immunizations and screening tests remain important, the most promising role for prevention in current medical practice may lie in changing the personal health behaviors of patients before clinical disease develops. There is a growing body of evidence linking a handful of personal health behaviors (smoking, failure to use safety belts, driving while intoxicated, physical inactivity, dietary patterns and sexual practices) to the leading causes of death.

Despite sound clinical reasons for emphasizing prevention, studies have shown that physicians often fail to provide clinical preventive services. This is due to a variety of factors, including lack of reimbursement for preventive services, lack of time, uncertainty about which services to offer and skep-

ticism about clinical effectiveness.

Publication of the U.S. Preventive Services Task Force Guide to Clinical Preventive Services marks the beginning of a new phase in the battle against premature death and disabil-

The body of the report consists of 60 chapters on specific screening, counseling and immunization topics. The task force rigorously reviewed evidence for 169 interventions and employed an explicitly documented methodology to evaluate the prevalence and impact of the diseases and to determine the efficacy and effectiveness of the interventions.

The task force found compelling evidence of effectiveness for a number of clinical preventive services (for example, newborn screening for phenylketonuria). However,

other preventive services had persuasive evidence of ineffectiveness (for example, screening asymptomatic persons for lung cancer with chest x-rays or sputum cytology). Some of the preventive services were not recommended for the general population, but were recommended for high risk groups.

A major theme of the guide is its emphasis on personal behavior and, therefore, behavioral counseling by clinicians. Improved control of behavioral risk factors such as use of tobacco, alcohol and other drugs, lack of exercise and poor nutrition could prevent half of premature deaths, one-third of all cases of acute disability and half of all cases

of chronic disability.

Based on this rigorous review, the task force provided eight age-specific charts for periodic health examinations. The preventive services appearing in these charts include only those that would be performed by clinicians on asymptomatic persons in the context of routine health care.

The task force judged it especially important to tailor the periodic health examination to the individual needs of the patient and emphasize preventive services that have been proven effective. This is done by focusing on the leading causes of illness and injury for the patient's age, sex and other risk factors and on the potential effectiveness of clinical interventions in altering the natural course of those illnesses and injuries.

The clinician whose time is limited is best advised to use this information to target preventive measures toward those conditions most likely to significantly influence the health and well-being of the patient.

The recommendations of the U.S. Preventive Services Task Force provide an excellent guide to the primary care physician regarding basic clinical preventive services.

For a summary of the U.S. Preventive Services Task Force Guide to Clinical Preventive Services, contact Dr. Ronald Eckoff, Iowa Department of Public Health, at 515/281-5914.

This material is furnished by the Iowa Department of Public Health.

Letter to the Editor Speaks out for BME

Dear Editor:

I am writing you as a member of the Board of Medical Examiners and hope to be able to explain some of the concerns that physicians and the public may have about our function and the timeliness of our decisions.

Our charge in licensing is to assure the citizens of Iowa that the licensed physician is not only qualified and well trained but that he or she is of good moral character and is worthy of the implicit trust patients have in their physician. This requires a thorough investigation of the background of the applicant—not only of his or her training but also any disciplinary actions by boards in other states in which the physician has been licensed. We have the impression that Iowa may have had a reputation of being an easy state in which to obtain a license. We have quite a few applicants who have had trouble elsewhere and they may not admit this on their application. These are serious problems and we must resolve them before granting a

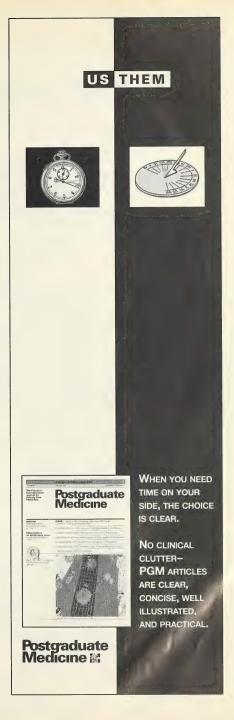
These problems range from sexual misconduct to drug abuse to even felonies. We have eight investigators working full time for the BME and much of their time is involved

in such investigations.

All of this information is strictly confidential and we cannot divulge anything—even that there is an ongoing investigation—until it is resolved. This may be difficult for a physician or a community to understand when they are anxiously awaiting the licensure of a prospective physician. A permanent license to practice medicine is permanent and is not easily revoked. An impaired physician presents a very difficult problem to his fellow practitioners and the hospital as well as a danger to his patients.

Sometimes there are delays in hearing from boards of other states or from the medical school or other sources of information which we contact. They may be working with constricted staffs as we are at the present time because of budget restraints.

We have a very capable and conscientious staff. Licensing is only one of our functions and we hope to inform you of other functions in subsequent letters.— *George Spellman, Sr., M.D., Sioux City.*



About Iowa Physicians

Items in this column are compiled from newspaper clippings from the Iowa Press Clipping Bureau. News from individual physicians, clinics and hospitals is welcomed and encouraged.

Dr. R. Josef Hofmann recently became a diplomat of the American Board of Eye Surgery. Dr. John Hoyt has retired after 46 years of medical practice in Creston. Dr. Hoyt received the M.D. degree from the U. of I. College of Medicine and helped found the Creston Medical Clinic. Dr. John Olds, Director of Medical Affairs at Iowa Methodist Medical Center, Des Moines, has become a diplomat of the American Board of Medical Management. Dr. John Denman has left Mercy Family Care in Osage to locate in Iowa City. Dr. Denman had practiced in Osage since 1990. Dr. Nancy Andreasen, psychiatry professor at the U. of I. College of Medicine, has received the Stanley R. Dean Award from the American College of Psychiatrists for her research in schizophrenia. Dr. Steven Wanzek, pulmonologist at McFarland Clinic in Ames, recently became board certified in critical care medicine. Dr. Y. Don Joo has left his practice in Clarinda to join a Veterans Administration hospital in Huntington, West Virginia. Dr. Joo practiced in Clarinda for three years. Dr. Henry Snead, formerly of Des Moines, has joined the medical staff at Covenant Medical Center, Waterloo. Dr. Donna DeLouis has left the Seymour Medical Clinic to join the practice of Dr. Gary Greenberg, Des Moines. Dr. DeLouis practiced in Seymour for four years. Dr. John Collins, Davenport, served as grand marshal of the Quad Cities' seventh annual St. Patrick's Day parade. Dr. Christopher Blodi,

formerly of Iowa City, has opened a specialty practice in diseases and surgery of the retina in West Des Moines. Dr. Marcus Emmons has retired after 54 years of medical practice; 46 of those years in Clinton. Dr. Emmons received the M.D. degree from the U. of I. College of Medicine and completed a residency at U. of I. Hospitals. He was the first Iowatrained psychiatrist to enter private practice in Iowa and helped found the Iowa Psychiatric Society in 1948. Dr. William Galbraith, Cedar Rapids, was recently elected a director of the American Board of Internal Medicine. The board sets standards of certification and recertification for internal medicine. Dr. Jerry Jochims, orthopedic surgeon from Burlington, has been awarded the Team Doctor of the Year award from the Iowa High School Athletic Association. Dr. Jochims was honored at the finals of the state basketball tournament at Veterans Memorial Auditorium in Des Moines.

Deaths

Dr. Kurt Hahn, 71, Burlington, died March 14 in Wiesbaden, Germany. Dr. Hahn received the M.D. degree from Christian Albrechts University, Kiel, West Germany and completed an ophthalmology residency at the University of Illinois Eye and Ear Infirmary.

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July 1992

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Iowa Medicine

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Dr. Carol Aschenbrener, former chairman, IMS Board of Trustees, took this striking photo during a vacation in Cape Cod last summer. Read more about Dr. Aschenbrener, who is leaving Iowa August 1, on page 295.

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President's Privilege



William Eversmann, Jr., M.D.

The stage is set

Between 1950 and 1987 so-called tort costs—essentially the cost of medical malpractice—increased 58 times relative to the gross national product. In most countries other than the U.S., these costs compare to approximately 0.5% of the GNP, but in the U.S. the comparison is 3.0%. Only welfare spending has increased faster.

Within the last 12-18 months, rate increases approaching as much as 10-15% for medical malpractice insurance are beginning to signal still another crisis for professional liability insurance. Also, insurance mechanisms which offer reduced rates for professional liability insurance have entered the market. However, in the midst of an insurance crisis they have limited staying power.

The frequency of medical liability claims is increasing 9% per year; the severity of these claims is increasing 10% per year. These figures are similar to those in the early 1970s and early 1980s just before the crises of 1975 and 1985 and 1986. Verdicts in medical malpractice litigation over one million dollars which peaked in 1985 and then decreased are climbing again.

Within the last 10 years, we have accumulated information which shows that tort reform stabilizes the cost of medical malpractice insurance and yet provides compensation where there has been injury resulting from medical treatment. As a percentage of medical liability across this country, the cost for

Californians has dropped following their tort reform package of 1975 which was not sustained by the California Supreme Court until 1985.

Ohio enacted tort reform and stabilized cost of medical liability. With reversal of that tort reform package in the courts, Ohio has noted an increase in the cost of medical liability.

There can be no question that circumstances during the forthcoming insurance crisis are considerably different than in the past. Presently, there are 22 bills pending in Congress, 12 of which are free-standing and directed toward the medical liability problem. The business community has begun to realize that professional liability insurance increases health care costs and affects employers' ability to provide health care insurance.

Anticipating that the insurance crisis may well develop within the next 18 months to two years, the stage is set for an increasing dialogue on health care reform.

The Medical Society continues to maintain vigilance in this area. We continue to maintain an updated tort reform package as part of our legislative initiatives. As health care reform is discussed, tort reform must be part of those discussions.

This is not a new wolf at the door but one with which we are familiar, recognized as a significant factor in health care costs by not only the medical community, the business community and politicians as well.

Psychotropic Medication Use in Long-Term Care

The Iowa Foundation for Medical Care is sponsoring a day-long educational program to assist practitioners and allied long-term care professionals in appropriate use of psychotropic medications in the geriatric population.

Program objectives will help participants:

- Identify policy and procedure changes required by OBRA legislation.
- Identify appropriate drug therapy and diagnosis.
- Identify means or methods for reducing psychotropic medication use among facility residents when appropriate.
- Review assessment, documentation, and care planning requirements when implementing reduction of psychotropic medications.
- Understand ways to manage side effects and difficult behavior resulting from drug reduction.

When: Thursday, August 20, 1992 University Park Holiday Inn Where:

1800-50th Street Clive. IA 50325

For hotel reservations, call the University Park Holiday Inn at (515) 223-1800 by July 29, A block of rooms

has been reserved; the corporate room rate is \$78 single, \$88 double.

Designed for: Physicians, Medical Directors, Pharmacists, Nursing Home Administrators, and Directors of Nursing Program Cost: The program costs \$95 which includes tuition, continental breakfast, lunch, snacks, information packet, and

Program Reservations: Co-sponsors:

CEU/CME processing costs. Fill out the registration form, include a check for the cost of the program, and mail before August 5 to the lowa Foundation for Medical Care. If you have questions, call Marie Hacke at the IFMC at (515) 223-2137.

University of Iowa College of Medicine, Des Moines Area Community College, Iowa Pharmacists Association, Iowa Association of Homes for the Aging, and Iowa Council of Health Care Centers

George T. Grossberg, M.D.

Keynote Speaker:

Director, Division of Geriatric Psychiatry Department of Psychiatry and Human Behavior

St. Louis University Medical Center

St. Louis, MO

Panel Members:

Moderator: Robert Bender, M.D., Family Physician: Mercy West Medical Clinic: Clive, IA

OBRA and

State Regulations: Jim Leslie, R.Ph., Hammer Pharmacy, Des Moines, IA

Attending

Psychiatrist: Judith H.W. Crossett, M.D., Ph.D., Cedar Center Psych. Group, Cedar Rapids, IA

Psychiatric Linda Garand, R.N., M.S., Abbe Center for Community Mental Health,

Nurse: Cedar Rapids, IA

Jim Miller, B.S., R.Ph., Ruegnitz Drug, Dubuque, IA Pharmacist:

Medical

Ronald Roth, M.D., Family Physician, Associated Medical Arts, Waterloo, IA

Continuing **Education Units:** Director: Applying for CEU/CME credit through the University of Iowa College of Medicine (physicians, medical directors — 6 CME), Iowa Pharmacists Association (pharmacists — .6 CEU), and Des Moines Area Community

College (nursing home administrators, directors of nursing — .6 CEU).

Registration Form

Psychotropic Medication Use in Long-Term Care August 20, 1992 (Register by August 5)

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Name		Soc. Sec. #
License #		
Nurse Physician		
Position/Title		
Employer		
Preferred Mailing Address		
City		
Telephone (day)	(evening)	
Amount Enclosed \$ Mail to: Iowa Foundation for Medical Care, 6000		

The Editor Comments



Marion E. Alberts, M.D.

Independence

THE FOURTH DAY OF JULY is meaningful to Americans, for on that date we celebrate our independence. Independence Day is unique for us and the rest of the world because "the United States is the only country with a known birthday" (James G. Blaine, American statesman, 1830-93). The guns of the Revolution were silenced and the colonies declared their freedom without a dissenting vote. As years passed, the Fourth of July became a great day of celebration. Parades, oratory and fireworks declared our status. John Burroughs, the naturalist and nature writer (1837-1921), stated "that which distinguishes this day from all others is that both orators and artillary-men shoot blank cartridges." Orators do have a way of uttering many words without saying much. Often, I am sure, they spend too little time planning and polishing their utterances and speak with their mouths rather than true knowledge of the subject.

So it is with many politicians of today. We are in the midst of political oratory directed to the elections of this fall. Numerous words are spoken. True issues are often skirted and there is much ado about matters which often pertain to a small segment of our voting population. Certain subjects have emotional appeal and the oratory aids in stir-

ring the emotions so conclusions drawn are not necessarily based upon rational and knowledgeable judgments.

The oratory of the coming elections should center on issues that concern all citizens rather than various activist groups. The seekers of public office must address the broad issues of the health and general welfare of everyone. Promises need not be loosely given, for often they cannot be honored. Most Americans are astute enough to ascertain the differences between "soft-soap," sincere reflections of the matters at hand or just more piles of verbal "bull."

It becomes the task of the voter to sort the chaff from the grain. Emotionalism is to be avoided. The issues must be faced head-on. Whom can we trust? Will the officeholder value our trust or was the oratory only a stepping-stone to participate in the outland-ish "perks" officeholders are prone to develop and perpetuate?

So on Independence Day of 1992 reflect on the meaning of the day. Exercise *your* independence. Be astute in listening, evaluating and ultimately voting for a given candidate. Be not fooled by the "blank cartridges" of oratory. Be a smart voter, that you do not "smart" later because of being taken in by

r- false utterances.

IMS presidents address House

Outgoing and incoming IMS presidents offered valuable insights to fellow physicians at the 1992 IMS House of Delegates.

Avoid the trap of cynicism

R. Bruce Trimble, M.D.

Mason City, Iowa

I HAVE USED THE President's Privilege page in *IOWA MEDICINE* this past year to give my thoughts on various issues we face. I'd like to reflect for a few minutes on an attitude we might cultivate. This is the attitude of simplicity or openness or lack of cynicism.

As we mature as clinicians, we all learn the importance of taking the patient and his or her complaints at face value. We learn that to make an initial judgment that the patient is hysterical or confused or looking for secondary gain does not excuse us from the obligation thoroughly to explore and explain, for instance, complaints of fatigue or joint pain or headache.

As we gain experience and self-confidence, we find that considerations of motive frequently impede exploration of the problem, and suspicions of the patient impairs the trust central to a productive patient-physician relationship. We are very uncomfortable with the occasional patient who clearly does not believe us. Surely patients must feel the same

way, so experienced physicians learn to approach patients with openness. Distrust, if you will, is inefficient. Now of course we may occasionally find that a patient is manipulative or does somatize but that is a conclusion reached after careful investigation, not a dismissive initial judgment.

There is an analogy between this clinical approach and the way we deal with other groups and individuals on the complex societal problems affecting the whole profession.

It has been my role frequently to represent the medical society to other groups. I regret to say that I have sometimes been cynical about the motives of others, and in fact developed this theme in part to clarify my own thoughts. Rarely has the cynicism been justified. Far more often, others have been equally uncertain about the issues; have had legitimate concerns, once understood; and have shown an honest interest in the voice of medicine.

The dictionary gives pessimism as one synonym for cynicism; if we don't trust others then we aren't likely to expect our dealings with them to be successful. Cynicism can be a ready excuse for lack of effort or for failure.

Cynicism is not sophisticated, but on the contrary is frequently a cover for insecurity

and lack of knowledge. In my experience, truly big people are rarely cynical; little peo-

ple frequently are.

Does avoiding cynicism mean we will always get our way? Of course not. Issues are complex and other interests are well organized. We will continue to lose in some situations and to have to compromise in others. But since openness, or lack of cynicism, means focus on substance rather than motive and openness to others begets openness to our views in turn, it does mean we are able more efficiently to focus on issues and more effectively to represent our interests.

We will deal with serious and complex issues this weekend and in the future. We have too much responsibility for the profession and our patients, too much to offer the public to indulge in cynicism. Let us avoid

that trap.

'Talk to your patients'

William Eversmann, Jr., M.D.

Cedar Rapids, Iowa

Health Care reform is upon us. The dialogue on health care reform fueled by the media and certain politicians, and encouraged by businessmen who are tired of paying more than their share and government that doesn't pay its share, have goaded the public who seemingly are asking for health care reform.

In reality we have an excellent health care system, albeit one with some problems. The health care system with which we live and practice has reduced the death rate from heart attack, cancer and stroke by better than 20-30% in the last 20 years. If it were not for these advances and the skill of surgeons, oncologists, radiologists and others, I myself would not be here.

As a profession, medicine continues to meet the challenge of curing disease and prolonging life. But what about the cost?

The increased cost is not inflation. Inflation is paying more for the same product. We have a better health care product today than we did even a year ago.

Dr. Edward Hughes, director of the Center for Health Services and Policy Research at



R. Bruce Trimble, M.D., immediate past IMS president, passes the presidential gavel to William Eversmann, Jr., M.D.

Northwestern University, suggests 10 reasons for rising health care costs.

The first is demographics. People are living longer. The average cost of health care per year per person over 75 years of age is \$6600.

Second, some health professionals are in short supply and higher wages are needed to attract therapists, technicians, nurses and other support staff.

Third, more physicians than are necessary provide more services than are necessary, though I doubt this is a problem in rural Iowa.

Fourth, increasing technology. Yes, Alice, a CT costs more than a routine radiograph and an MR costs more than a CT. There are other examples outside radiology.

Fifth, patient demand increases the cost

of health care.

Sixth, the illicit use of drugs and the AIDS epidemic throughout the U.S., particularly in cities, increases the cost of health care.

The seventh cause of increased health costs is medical liability which increases the cost of care through defensive medicine. The cost of malpractice insurance is passed on to patients.

(Continued next page)

The eighth cause of increased cost—the uninsured and under-insured—shift the cost of their care to other payors. Because these persons lack preventive care, they often present with more severe illness which is more costly to treat.

Government regulations increase the cost of health care as we must hire additional personnel to provide the utilization review, the additional administrative hassle which both the federal government and insurance companies create. This is the ninth factor in the increasing cost of health care.

The tenth factor of increased cost of health care is the redundancy in our medical system often due to government and federal trade regulations, occasionally due to medical

competition.

Five groups must work together to control costs—it cannot be the responsibility of

one group alone.

Physicians and hospitals are only one of these groups but usually are blamed for the total problem. This is certainly true as we review the document of the Iowa Leadership Consortium where physicians in various organized delivery systems compete for dollars like wild animals fighting over fresh meat while the high commissioner of health care washes his hands while health care delivery is crucified.

'We have too much responsibility for the profession and our patients, too much to offer the public to indulge in cynicism.'

- R. Bruce Trimble, M.D.

I believe we as physicians have a responsibility to adjust for the benefit of our patients but be aware that we have been cost effective, we have controlled costs, we have provided expert care and we must continue to do so.

What of the other groups? The insurance industry under the Iowa Leadership Consortium will sell more insurance to more people, even the poor with subsidized policies. By selling management contracts for organized delivery systems they will benefit again. The

insurance industry wrote the ILC document.

The legal profession comprises the third group. Medical liability continues to increase costs. The cost of litigation can only be controlled with the cooperation of both the medical and the legal professions.

The fourth group which must be involved in the control of health care costs is the pharmaceutical and medical supply industries. I was recently encouraged to hear that the Synthese Corporation had a simple but neat exhibit at the American Academy of Orthopedic Surgeons annual meeting rather than the lavish one of its competitors and then donated \$100,000 to orthopedic research.

'Patients respect, even love, their doctor but at the same time dislike physicians as a group.'

- William Eversmann, Jr., M.D.

Last but not least, possibly the most important group, the public. The public appetite for health care must be controlled. If not, they will be plagued by the politicians with a National Health Care System which as Louis Sullivan has indicated would have the compassion of the Internal Revenue Service and the efficiency of the post office.

How can some 3,000 Iowa physicians have an effect on the delivery of health care? I believe we can have the most effect through our patients. Patients respect, even love, their doctor but at the same time dislike physi-

cians as a group.

We need to capitalize on each patient's respect for us as their physician by meeting their needs as physicians to the best of our abilities while at the same time informing them about their health care system and the effect of proposed changes. Talk to them about costs, why the cost is increasing and who needs to be involved to control the cost.

What can we do as a medical society? We need to work together, consolidate our strength and grow so that just as biological organisms grow and bear fruit, so this society can grow and serve this profession and our patients.

IOWA MEDICINE Spotlight

IOWA MEDICINE talked to members of the lowa Medical Society at the IMS Annual Meeting April 24-26. We asked the following question:

Proposals to reform our health care system are numerous. After the dust settles, what kind of health care delivery system do you think we will have?



David Van Gorp, M.D. Family physician Orange City



Emmett Mathiasen, M.D. Surgeon Council Bluffs

"There's no doubt there will be more and more government regulation of medicine. I only wish there was some way to cut through the red tape. I fear it will be such a hassle that quality people will not go into medicine." "I don't think we'll have national health insurance unless a new president and more Democrats in Congress push for it. When national health care is explained to the people, they won't accept it. People want to know their doctor."



Robert McCool, M.D. General practice Clarion



"We're going to end up with socialized medicine and pharmaceuticals run by the government. As the chasm between the cost of medical care and the income of doctors deepens, national health care will inevitably fill the vacuum. Some people won't be any worse off than now."



"It's very intimidating going into a field with such dramatic changes taking place, but I believe we have quality people ready to meet the challenge. Eventually, it will come down to some form of health care unified under a single insurer. It's definitely coming."

Iowa physician played with the best of the Big Bands

No one would imagine this mildmannered, retired Urbandale family physician actually played with the most famous musicians of the Big Band era— including the greatest drummer of them all.

S TEWART OLSON BEGAN PLAYING the clarinet because he was afraid. He continued playing because he was good at it. Good enough to eventually earn a place in Gene Krupa's band, play in the best jazz clubs and rub elbows with the greats of the Big Band era.

Dr. Olson, a retired family physician living in Urbandale, recalls it this way:

"My brother was supposed to be the musician, but he quit because the teacher smoked cigars. Our mother had saved egg money to buy the clarinet, and she told us 'Somebody's going to play this thing.' So, I learned because of fear."



As a 12-year-old in rural North Dakota, Dr. Olson practiced his clarinet and listened to Benny Goodman on an old Philco radio. During high school, he was good enough to play with college bands. When it was time to graduate, someone told young Stewart that the best career path was to 'do the thing you do the best.'

"The thing I did best was play the clarinet," he says.

He went on to the Vandercook School of Music in Chicago, but dropped out after one quarter. He got acquainted with the saxophone player for Boyd Rayburn's band and landed a job. His first professional "gig" was at the Chez Paree club in Chicago. He was 21 years old and it was 1940.

"Every musician's goal is to play with the best band around—not a bunch of foot

draggers. I was lucky."

By this time, Dr. Olson could play the clarinet and the baritone sax and was touring the country with Rayburn's band. He met his future wife Mary Helen in Minneapolis (the two had gone to school together) and joined Sonny Dunham's band when the Rayburn band "petered out."

Then his path crossed that of drummer

Gene Krupa.

"Krupa started with Benny Goodman, but in 1944 he got arrested for marijuana possession and changed to the Tommy Dorsey band. Before long, he started his own band and I joined. We played some great places—the Orpheum in Boston, the Capitol Theater in New York and the Sherman Hotel in Chicago," Dr. Olson recalls.

Anyone who has heard Krupa play the drums on his theme song "Sing, Sing, Sing," will understand Dr. Olson's continuing admiration for his talent.

"He was from a Catholic Polish family in Chicago—even went to a seminary for a while. You know, playing the drums like he did required lots of physical stamina. He'd sweat like crazy when he played and when we got on the bus to leave, he'd fall asleep immediately."

His most memorable experiences were playing at the Astor in New York on V-J Day and appearing with the Krupa band in the movie "George White's Scandal of 1945." (His son recently gave him a tape of the movie for a Christmas present.)

Then, Mary Helen became pregnant and, in September of 1945, Dr. Olson quit the band because they didn't want to travel from town to town with a baby in tow. At that point, fate intervened—once again in the form of his brother.

"My younger brother was a doctor, and I decided that if he could do it, so could I. So I enrolled at Northwestern University," he says.

While at Northwestern and later at the University of Minnesota, Dr. Olson did a little playing with local bands because he still had a union card. But, it was disappointing.

"Playing with these bands was hard be-

cause I'd played with the best."

He interned at Iowa Methodist in family practice, stayed in Des Moines and retired in 1990. He has no regrets about leaving the music field, but says he's glad he had the experience of traveling and playing music so he "wouldn't have any regrets."

Now, Dr. Olson, who has four children, plays his clarinet mostly at family occasions and recently played Mozart at his daughter's

back yard wedding.

He plays the clarinet every day since he retired but received a warning from his wife.

"She told me 'You're not playing any gigs—I've sat alone enough," he relates, smiling.

Dr. Olson loves listening to Big Band music, especially Count Basie because he had "the best swing band of all." As for his most admired musician, that nod goes to Lionel Hampton.

"He was a wonderful player and a good Republican, too," concludes Dr. Olson.



A young Stewart Olson, playing his clarinet (at right), was photographed with members of Gene Krupa's band.

The ministry of medicine

Following are excerpts of remarks written by a pastor of the Plymouth Congregational United Church of Christ for a special worship service held during this year's annual House of Delegates meeting.

Pastor Alden Hebard

Des Moines, Iowa

THE ROLE OF THE MEDICAL person has always been exalted. Today, with the help of technology that can enhance diagnosis, the medicine person is more exalted than ever.

Ministry is a special caring in which we permit ourselves to be lesser in the service and in the interests of others whom we permit to be greater in their need. Given the exaltation of the physician in contemporary culture and the often built in arrogance that comes when a person is in control of another's situation, you can see why the ministry of medicine may well be an oxymoron. But it need not be.

We are living in a time of enormous challenge to medicine. I have attended several seminars dealing with medical ethics with regard to neo-natal care, prolongation of life, reproductive possibilities, and so on. Technology is at once our friend and our tyrant.

All of this has created several dilemmas for the modern physician in even trying to tie together ministry of medicine. We have alluded to the tension between major and minor, or in other words, between humility and arrogance. The miracle of the body itself and the fact that in most instances the physician uses knowledge to assist the body to do its work, needs to be kept before us.

The second tension is between seeing the patient only in the focus of a specific disease, or in the larger context of the patient's environment.

A. J. Heschel writes in the article, "Religion and Medicine: A Meditation:" "Ironically, with the instrumentalization of modern medicine, the patient is seen as a passive recipient of medical expertise, and he or she can no longer be seen as a person with a life story. Yet it is only within a life story that illness has a meaningful place. And to see the patient's illness as a development in a biography—rather than as an isolated series of biological events—is precisely to recover a context of meaning for medical interventions."

The third tension is between caring and curing. Obviously both are part of the relationship between physician and patient.

When I met a friend surgeon in the hall-way of Methodist Hospital, he said, "Say a prayer: I have to deliver bad news." Well, my typical prayer beside a patient's bed is this: O God, we know that you are present with us, and that you work through the doctors in caring for us...

Medicine is a ministry when the physician understands that he/she is working with a miraculous creation, and who through expertise, experience, training and attention can assist in wellness; when we can see the intervention within a total context; and when we can live with the paradoxes of humility and exaltation, caring and curing.



Farewell, Dr. Aschenbrener

cil on Medical Education and is also a member of the Liaison Committee on Medical Education and the Accreditation Council on CME.

Dr. Aschenbrener summed up her philosophy of medical practice in a recent speech at the U. of I. College of Medicine commencement.

"As health professionals, you will continue to sacrifice time and energy in the service of others. You will forgo some recreational hours for continuing education to maintain competency. You will miss some family occasions to sit with a patient who needs you more. The sacrifice will continue but the rewards of giving and learning will be immeasurable.

"As health professionals, you will have influence and the power to get things done. What agenda will you set to use you influence and power for the good of others? What example will you give? What values will you be willing to work, pay, fight and suffer for?

"Few of us will achieve greatness in the eyes of the world. But each of us has the ability and opportunity to approach the tasks of daily life in a great way."

THE IOWA MEDICAL SOCIETY is losing a valuable and highly-regarded member.

Dr. Carol Aschenbrener, executive associate dean for the University of Iowa College of Medicine, will begin a new post as chancellor at the University of Nebraska Medical Center beginning August 1.

Dr. Aschenbrener—who was the first woman member of the IMS Board of Trustees—has served the Society in many other capacities and took the photograph which graces this month's IOWA MEDICINE cover. A year ago, she was elected to the AMA Coun-

\$30,000 BONUS OFFERED TO HEALTH CARE PROFESSIONALS

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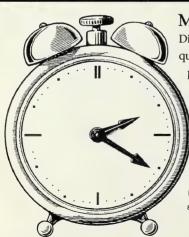
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Annual Meeting photo highlights



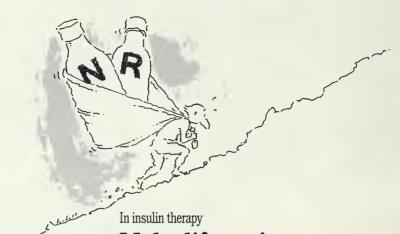


(Clockwise from above) At the annual banquet, Jackson Ver Steeg, M.D., chairman of the Iowa Medical Political Action Committee Board of Directors, holds a plaque honoring IMPAC as the top state medical PAC in the nation; Emmett Mathiasen, M.D., receives the 1992 IMS Merit Award from Dr. Carol Aschenbrener; banquet goers were entertained by the swing/jazz sounds of Rick Dean and the Raiders from the Lost Art of Mason City; Donald Kahle, M.D., House speaker (behind podium) holds a "sidebar" conference on proper procedure during the Sunday session of the House of Delegates; Warren Wulfekuhler, M.D., chairman of the IMS Medical-Legal Committee, with Diane Kutzko, the Iowa State Bar Association representative to the IMS. Ms. Kutzko was the recipient of the John F. Sanford Award.









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IMS 1992 House of Delegates

April 25-26, 1992 OFFICIAL PROCEEDINGS

The 1992 ANNUAL MEETING of the Iowa Medical Society House of Delegates was held April 25-26 at the Des Moines Marriott Hotel. House sessions were chaired by Donald Kahle, M.D., speaker. Open hearings were conducted by three reference committees on April 25. The annual banquet was held April 25 and was chaired by IMS President R. Bruce Trimble, M.D.

IMS Awards

At the annual banquet, Emmett Mathiasen, M.D. a Council Bluffs general surgeon, received the 1992 IMS Merit Award.

The Ben T. Whitaker Interstate Teaching Award was given to John Olds, M.D., a Des Moines internist. The Outstanding Medical Office Administrator Award was given to Ed Maahs of the McCrary-Rost Clinic in Lake City.

The John F. Sanford Award was given to Diane Kutzko, a Cedar Rapids attorney who is the Iowa State Bar Association liaison to the IMS. The Washington Freeman Peck Award was given to the American Lung Association.

Also at the banquet, the Iowa Medical Political Action Committee (IMPAC) received an award in recognition of being the top state medical PAC in the nation.

The award was presented to Dr. Jackson Ver Steeg, chairman of the IMPAC Board of Directors, by Dr. Tim Flaherty, a member of the AMPAC Board of Directors.

April 25 session

Registered for the April 25 session were 143 delegates. Minutes of the 1991 House of Delegates session were approved as summarized in the July, 1991 issue of *IOWA MEDICINE*.

New delegates to the House were introduced and reference committee appointments were announced.

Dr. John Clowe of Schenectady, New York, president-elect of the American Medical Association, addressed the House. He discussed health care reform proposals and AMA negotiations with the federal government regarding RBRVS and other issues.

Reports contained in the 1992 House of Delegates handbook were approved, with the exception of the following: reports from the Committee on Redistricting and the Judicial Council were referred to the Reference Committee on Reports of Officers and Miscellaneous Business. The report of the Committee on Young Physicians was referred to the Reference Committee on Legislation.

Two checks totalling \$16,400 were prsented on behalf of the AMA-Educational and Research Foundation to James Clifton, M.D., acting dean of the University of Iowa College of Medicine.

It was acknowledged that nearly all the gifts came from the medical family and were recruited from physicians and their spouses by members of the Auxiliary.

CONTINUED INSIDE

Reports to the House

The following supplemental reports were submitted and referred to appropriate Reference Committees:

The IMS Board of Trustees and the Committees on Legislation, Delivery of Health Services, PRO Study, Single Medicare Payment Locality, Health Care Reform and Forensic Medicine.

The Necrology Report was presented by Dr. Robert Kent, chairman of the IMS Judicial Council, with delegates observing a silence in honor of deceased physicians.

The report of the Nominating Committee was approved as submitted and nominating speeches were made on behalf of several candidates for office.

Informational reports were presented from the Iowa Medical Foundation, IMS Services, Iowa Physicians Mutual Insurance Trust, the Society's AMA delegation and the Iowa Foundation for Medical Care.

Outgoing president R. Bruce Trimble, M.D. addressed the House. His remarks are reprinted elsewhere in this issue. Following his remarks, Dr. Trimble congratulated Dr. Carol Aschenbrener, IMS Board of Trustees, on her appointment as chancellor of health sciences at the University of Nebraska beginning August 1.

Policy resolutions submitted by county societies, councilor districts and others were formally introduced and referred to appropriate Reference Committees. Actions taken on these resolutions are reported subsequently.

Life Members

The following physicians were elected to Life Membership in the Iowa Medi-

cal Society:

John Dixon, M.D. and Paul Morgan, M.D., both of Mason City; Herbert Neff, M.D., Panora; John Scheibe, M.D., Bloomfield; Harvey Eastburn, M.D., Burlington.

Webster Gelman, M.D. and Jeanne Smith, M.D., both of Iowa City; William Owen, M.D. of St. Ansgar; Clifford Losh, Jr., M.D., Des Moines; Richard Rogers, D.O., Grinnell.

Roger Anderson, D.O. and Joseph Prior, D.O., both of Davenport; John Bacon, M.D. and George Montgomery, M.D., both of Ames; Fortunato Neglia, M.D., Maxwell; Charles Semler, D.O., Story City.

James Worrell, M.D., Keosauqua; Dennis Emanuel, M.D., Lloyd Gugle, M.D. and Walter Herrick M.D., all of Ottumwa.

Jay Miller, M.D., Wellman; and Arthur Gelfand, M.D., Sioux City.

Emeritus membership in the Iowa Medical Society was accorded to 43 physicians.

The speaker presented information on the Reference Committee hearings, election procedures and the concluding session of the House.

April 26 session

Registered for the April 26 session of the House were 126 delegates. Minutes of the April 25 session were read and approved.

Mrs. Martha Holzworth, immediate past president of the IMS Auxiliary,

spoke to the delegates about Auxiliary projects during her term. Mrs. Priscilla Gerber, president-elect of the AMA Auxiliary, also addressed the House.

The following physicians were announced as having been elected or reelected to the positions noted.

President-elect: John Anderson, M.D., Boone.

Vice-President: Harold Miller, M.D., Davenport.

Speaker, House of Delegates: Donald Kahle, M.D., Dubuque.

Vice Speaker, House of Delegates: Tom Throckmorton, M.D., Spencer.

Trustee: William McMillan, M.D., Ottumwa.

AMA Delegates: Clarence Denser, Jr., M.D., Des Moines; John Rhodes, Sr., M.D., Pocahontas; Donald Young, M.D., Iowa City.

AMA Alternate Delegate: Clarkson Kelly, M.D., Charles City.

Four District Councilors were also affirmed during annual elections: District 1 — Robert Kent, M.D., Burlington; District VII —Don Orelup, M.D., Albia; District XII — John Brinkman, M.D., Mason City; District XIV — Linda Iler, M.D., Lake City.

The speaker acknowledged the efforts of the Reference Committees. Following adjournment of the House of Delegates, William Eversmann, Jr., M.D. was installed as president of the IMS for the coming year. His inaugural comments are published elsewhere in this issue.

Organizational meetings of the IMS Board of Trustees and Judicial Council occurred following Dr. Eversmann's installation.

House acts on policy resolutions

CONTINUED FROM PAGE 2

The IMS will take the following actions based on House consideration of 3 Reference Committee reports:

•Accept a Board of Trustees' recommendation that IMS dues for 1993 be raised \$20 to \$370 per member.

 Analyze and report the impact of pending and enacted federal and state legislation and regulations on the availability and accessibility of medical care.

 Urge the IFMC Board to pursue no further bylaw changes until a new IFMC Board has been elected.

 Urge the IFMC Board to pursue election of a new board of directors as soon as possible.

•Urge the IFMC Board to change its voting procedure for membership approval of proposed bylaw changes to require a simple majority of those voting.

•Request the American Medical Association to keep members informed of federal legislation and regulation.

•Encourage the American Medical Association to support a nationwide mini-internship program for members of the U.S. Congress.

 Encourage practicing physicians to serve as members of the Board of Medical Examiners.

*Refer the following resolution to the appropriate committee to study possible use of confidential information available to the BME and possible conflicts of interest between service on the BME and an appearance as an expert witness in a malpractice case and report back to the 1993 House of Delegates:

"The IMS is to introduce legislation to enforce a restriction on members of the Board of Medical Examiners prohibiting them from acting as expert witnesses in medical malpractice suits."

•Introduce legislation to enforce a requirement that to be a member of the BME, a physician must maintain current, active clinical practice with direct ongoing responsibilities for patient care.

•Refer the following resolution to the appropriate committee:

"The IMS is to adopt the January,

1992 recommendation of the Infectious Diseases Society of America in lieu of the AMA position on HIV infected health care workers."

•Refer the following resolution to an IMS committee for further study:

"The IMS is to urge the legislature to eliminate the need to prove special injury in lawsuits which countersue for malicious prosecution."

CONTINUED BACK PAGE

New IMS Councilor Districts

At the April 26 House session, delegates approved an IMS redistricting plan which calls for the following:

DISTRICT	COUNTIES
I	Des Moines, Henry, Jefferson
	Keokuk, Lee, Louisa, Van Buren
II	Johnson
III	Clinton, Muscatine, Scott
IV	Cedar, Jones, Linn
V	Allamakee, Clayton, Delaware
	Dubuque, Jackson
VI	Cerro Gordo, Chickasaw, Fayette
	Floyd, Howard, Mitchell
	Winneshiek, Worth
VII	Benton, Black Hawk, Bremer
	Buchanan, Butler, Grundy,
	Iowa, Tama
VIII	Boone, Hardin, Jasper, Marshall
	Poweshiek, Story
IX	Adams, Appanoose, Clarke, Davis
	Decatur, Lucas, Mahaska, Marion,
	Monroe, Page, Ringgold, Union,
	Taylor, Wapello, Wayne
X/XI	Madison, Polk, Warren
XII	Adair, Audubon, Cass, Dallas
	Fremont, Guthrie, Harrison, Mills
	Montgomery, Pottawattamie, Shelby
XIII	Calhoun, Carroll, Crawford
	Greene, Hamilton, Ida, Sac, Webster
XIV	Buena Vista, Clay, Dickinson, Emmett
	Franklin, Hancock, Humboldt, Kossuth
	Palo Alto, Pocahontas, Winnebago, Wright
XV	Cherokee, Lyon, Monona, O'Brien
	Osceola, Plymouth, Sioux, Woodbury

House actions

CONTINUED FROM PAGE 3

•Remind physicians they are to be guided by standards of good medical practice and not financial interests and, if conflicts arise, they must be resolved to the benefit of the patient.

•Amend the IMS Articles and Bylaws in order to develop and implement a deputy councilor system which would allow deputy councilors to attend and vote at Executive Council meetings if the Councilor was unable to attend.

•The IMS PRO Study Committee is to be renamed the PRO Advocacy Committee and the committee is to take a more active role in assisting physicians with the PRO process.

•Urge IMS members interested in peer review to run for election to the IFMC Board of Directors.

•Inform physician members regarding the IFMC nomination and election process.

•An IMS representative is to regularly attend board meetings of the IFMC and the IMS is to publish a summary of these proceedings after each meeting, exclusive of areas of confidentiality.

•Publish ongoing reports regarding IFMC performance in relation to other peer review organizations.

•Reaffirm that whenever possible, a review of a physician should be done by a physician in the same specialty.

 Continue its specialty reviewer recruitment and routinely provide the IFMC with physicians interested in becoming IFMC reviewers.

•Report to the 1993 House of Delegates regarding specialty reviewer availability and request the IFMC to provide in their annual report to the IMS statistics on first and second level peer vs. non-peer specialty review.

•Urge the IFMC to review all 25point accumulations in a quarter through a separate IFMC physician committee process before a physician is notified of a potential sanction. •Initiate a program for members of the U.S. Congress (Iowa delegation) to spend a day with a physician.

 Oppose discrimination in Medicare reimbursement practices based on age or years in practice.

 Work closely with the AMA to seek repeal of reimbursement provisions in Medicare regulations which discriminate against new and young physicians.

*Supportappropriate handling and disposal of medical waste in order to protect the public and waste disposal workers from possible infection.

*Support an extension of the current moratorium on the commercial incineration of medical waste in Iowa until the federal government issues an appropriate definition of medical waste with provisions for proper handling and disposal of such waste.

•Support current AMA policy on gun control.

•Work to encourage malpractice tort reform, including a cap on liability.

•Pursue all avenues to discourage enactment of the health care tax.

•Urge members to write U.S. representatives and senators in support of student loan deferment for the duration of residency training.

•Support examination by a physician in cases of suspected child abuse.

•Undertake an informational campaign to IMS members and the general public regarding the major health care reform proposals. This information should allow physicians and county societies to be better educators of their patients and better citizens in their local communities.

•Provide information to member physicians on economical methods of claims submission.

•In conjunction with the Univer-

sity of Iowa College of Medicine, the University of Osteopathic Medicine and Health Sciences, the Iowa Academy of Family Physicians and others, survey medical students, residents and practicing physicians leaving the state to determine factors which influence specialty choice, practice location and what could be done to increase the number of primary care physicians in Iowa.

•Work with the University of Iowa College of Medicine and, if appropriate, the Iowa Legislature, to investigate and develop additional methods and programs to encourage more medical students to enter primary care specialties, e.g., expanding the length of the family practice preceptorship in the third year and setting up a "rural track" program whereby clinical rotations are taken in a more rural setting.

•Work with the specialty societies and other appropriate organizations to develop incentives to make practice in rural areas more attractive to primary care physicians in order to provide access to necessary medical services in rural Iowa.

 Promote health education in all state schools, from primary through the university level.

 Assist county medical societies in identifying methods and resources in local areas to promote healthy lifestyles.

•With the IMS Auxiliary, continue participation in the Iowa Coalition of Comprehensive School Health Education in order to promote healthy life-style habits in school age children.

 Adopt a policy whereby United States Medical Licensing Exam (USMLE) scores should be communicated on a pass/fail basis and that this policy be communicated to USMLE.

*Support education concerning the use of helmets when riding open 2- and 3-wheel off-road vehicles.

Medical coverage for the Iowa Games, 1987-1990

The author summarizes the experience of the medical staff of the lowa Games competition from 1987-90. The rate of injuries decreased each year, perhaps because of the increased conditioning and experience of the athletes.

Mark Brodersen, M.D.

lacksonville, Florida

The Goal of the Iowa Games, which began in 1987, is to allow residents of the state to participate in an Olympic-style event and to compete against people of similar age and skill level. This paper summarizes the experience of the medical staff at the Iowa Games from 1987 to 1990. To date, there has been only one other report about the medical coverage of a state games event.¹

The nature of the Iowa Games has changed since 1987. Initially, all events were held in Ames and hosted by Iowa State University. Regional qualifying competition was established because of an increase in the number of participants (Table 1). Participants sign a waiver of indemnity and are advised to undergo a medical examination prior to competing. As in the

TABLE 1
PARTICIPANTS IN THE IOWA GAMES

	No. of	participants	
Year	Qualifying rounds	Finals	Total
1987	3,800	7,128	10,928
1988	6,000	9,173	15,173
1989	6,300	10,561	16,861
1990	4,494	12,092	16,586

Olympics, each sport has an organizing committee responsible for running the event, recruiting the officials and certifying the athletes.

Medical coverage

The Iowa Games Medical Director was appointed by the Sports Medicine Committee of the Iowa Medical Society and was responsible for supervising the medical care of the athletes and for working in conjunction with risk management and safety personnel. Guidelines were established for the medical staff and sent to each volunteer. Iowa Methodist Hospital in

THE IOWA MEDICAL FOUNDATION HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION AWARD FOR JULY 1992

Dr. Brodersen is a senior associate consultant at the Mayo Clinic in Jacksonville, Florida and an assistant professor of orthopedics, Mayo Medical School, Rochester, Minnesota.

Des Moines agreed to provide personnel and medical supplies. The head trainer supervised the assignment of medical personnel to the event venues.

In general, every attempt was made to place the most highly trained medical staff in the areas of greatest risk. Mary Greeley Hospital in Ames also cooperated by supplying medical personnel and having paramedics available for the opening ceremonies and the 5K/10K road race.

The goals of the medical personnel were to provide simple first aid and refer any serious injuries to the city hospital. Prophylactic taping and wrapping were done when trainers were available. Medical personnel filled out injury report forms which were used to analyze the number and type of injuries.

Each venue was provided with a Styrofoam ice chest, water supply, cots, bag of medical supplies and a two-way radio with a channel specifically for medical personnel. The

TABLE 2

NUMBER OF INJURIES IN THE IOWA GAMES

Year	No. of injuries
1987	94
1988	105
1989	79
1990	54

medical headquarters were in the men's main athletic training room at Iowa State University.

Demographics

Of the participants, 66% were males and 34% were females. The oldest participant was 89 years old, the youngest was 1 year old. The large number of athletes in the 10- to 14-year-old age group (29.2% of entrants) reflects the popularity of youth soccer.

Injuries

The number of injuries per year is presented in Table 2, and a breakdown of the specific types of injury is given in Table 3. The most common injuries were the least severe. From 1987 to 1990, the number of sprains decreased. It is thought that as participants better prepared themselves for competition and as their training improved, the injury rate decreased. In 1988, the weather was particularly hot and 13 participants required treatment for heat-related problems. At that time, pump waterers refilled by a portable tank were used. In 1989, a local bottled water distributor contributed a large stock of 5-gallon bottles of water. They were much easier to distribute and allowed support personnel to keep up with demand.

Bee stings and asthma were minor problems. The two major injuries were rib fracture and pneumothorax that occurred in a participant of the cross-country bicycle race in 1987 and a cardiac arrest in a participant in the 5K road race in 1990. A highway patrol officer

TABLE 3
INJURY TYPE IN THE IOWA GAMES

Injury type	1987	1988	1989	1990	Total no.	Average no per year
Sprains/strains	58	49	35	29	171	42.75
Bruise/contusion	19	13	15	11	58	14.50
Abrasion/blister	5	13	13	4	35	8.75
Laceration	3	7	6	5	21	5.25
Dental	2	1	1	0	4	1.00
Concussion	1	7	3	0	11	2.75
Foreign body/eye	1	0	1	0	2	0.50
Heat	2	13	2	1	18	4.50
Fractures	2	0	1	3	6	1.50
Bee sting	0	2	0	0	2	0.50
Asthma attack	0	0	2	0	2	0.50
Emotional reaction	1	0	0	0	1	0.25
Cardiac arrest	0	0	0	1	1	0.25
Total	94	105	79	54	332	83.00

called an ambulance to evacuate the injured participant to a local hospital. The participant recovered satisfactorily. The runner collapsed near the finish line; paramedics were on the scene immediately. The participant was defibrillated and stabilized within minutes and transferred to a local coronary care unit for observation. Recovery was uneventful.

Soccer had the highest number of injuries, but it also had the greatest number of participants. In general, there did not seem to be any sport that had an excessive number of injuries when the number of participants was com-

pared with the injury rate.

Summary

The Iowa Games have had a very positive effect on the amateur athletic movement in that state. The expertise of a well-coordinated medical team consisting of volunteer physicians, trainers and paramedical personnel has been an invaluable asset.

Reference

1. Noble, HB et al: The prairie state games: organization of medical care. Physician Sportsmed 1988 Feb;16:95-106.



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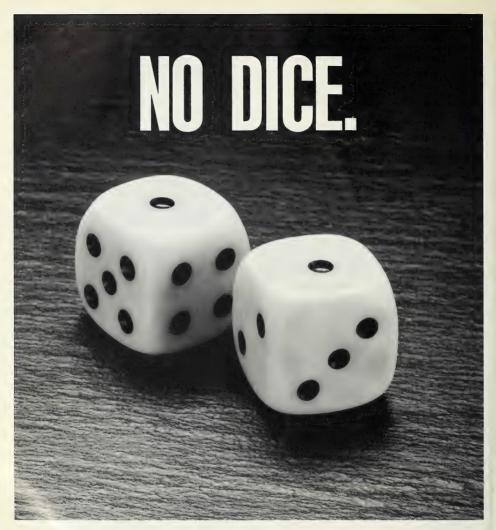
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The state of the art

Richard M. Caplan, M.D.

IN A 1988 BOOK, MD: Doctors Talk About Themselves, John Pekkanen presents comments by physicians concerning many aspects of medical life and practice. The quotations are remarkably well stated. Perhaps Mr. Pekkanen provided some skillful editing for his unnamed interviewees. No matter — most of them sound sincere and please me when they match my own perceptions and attitudes. The introduction reads:

... but the private world of doctors is ultimately replete with human emotion, with feelings of doubt, guilt, fear, anxiety, grief, and anger that reflect a lifetime of meeting human suffering head-on.

It is also a world divided between art and science, between technology and intuition. It's a world in which doctors find themselves both damned and deified, accused of arrogance, incompetence and greed, and looked to as saviors, helpers, and counselors. As one doctor said, "We're held anywhere from beneath contempt to above reproach." We are seldom neutral about doctors, and we are always fascinated by them.

In a recent editorial in the NEJM, the distinguished Harvard physician, Leon Eisenberg, cites a study by Good & colleagues, who

... found that only 20 to 30 percent of patients with emotional distress, family problems, behavioral problems, or sexual dysfunction reported those matters to their primary care providers. It is as if doctors and patients have a covert agreement that physical symptoms are the only legitimate tickets of admission to a doctor's office. Patients who are ready to say more often find their comments cut short by a doctor asking where the pain is and whether it is sharp or dull rather than asking about the circumstances, personal and social, in which it occurs . . . [T]he doctor as well as the patient . . . is unwilling to face the issues. Both may be uncomfortable in discussing sensitive personal matters. Exploring them also takes time, and time is at a premium. Thus, some doctors are themselves "somatizers"; to them, illness is real only when it is associated with verifiable organic pathologic features.

 $\mbox{Dr. Caplan}$ is Coordinator, Program in Medical Humanities at the University of Iowa College of Medicine.

One thrust of such assessments as these is to suggest why we all speak of "the state of the *art*" but not "the state of the *science*" or even "the state of the *technology*." As usual, our language and its metaphors reveal much. Another thrust draws attention to increasingly negative aspects of the medical world and its forecasted trajectory. Such predictions even cause some growing number of physicians to retire early and/or recommend to young people, including their own children, that they not enter medicine.

In the face of such discouragement, it is splendidly uplifting to note some data from a recent effort by the *Des Moines Register*, associated with their annual campaign to identify the "Academic All-State Team." Their pool of highly talented young people (one nominee per high school) was asked, "If you could accomplish any one thing during your life, what would it be and why?" "Be a doctor" (16 responses) came in 5th and was the only occupational category specifically named among the 19 categories of responses.

The higher-scoring responses were "Live up to my potential" (22), "Be successful in a career" (21), "Preserve the environment" (19), and "Help others in need" (17). But notice how being a doctor allows active accomplishment of those others (including even, to some extent, preserving the environment).

Such data, even though representing the naive idealism of youth, are a cause to rejoice. It is the young, after all, who will apply for admission to medicine and in that process bring cheer to those of us who have grown older but carry an idealism harder to quench. By those who have grown stubbornly pessimistic about a career in medicine, whether they be physicians or otherwise, I'm reminded of an encouraging comment made by a wise acquaintance who spoke about the stubborn attitudes toward curricular reform exhibited by many aging medical faculty members: "Although they may be immutable, they are not immortal."

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Patient confidentiality

Robert Weir, Ph.D.

IN MAY THIS COLUMN contained scenarios from a recent survey on patient confidentiality done at the National Institutes of Health. The purpose of this second column on confidentiality is to present the ethical rationale for the requirement of confidentiality and to discuss circumstances in which breaching confidentiality is morally justifiable and/or legally required.

Confidentiality is present when person A discloses information (through words, written documents, physical examination or lab tests) to person B, and person B refrains from disclosing that information to another person or party (person C, A's employer, A's insurance company, etc.) without A's consent. In medicine and many other contexts, confidentiality is a *prima facie* obligation that is binding unless and until it is outweighed by other obli-

gations.

Why is confidentiality important in medicine? First, the ethical principle of respect for autonomy includes, at the very least, respecting the privacy of patients and being sensitive to the extraordinarily personal nature of the information they divulge to physicians. Patients are sometimes willing to tell physicians and physicians are often able to discover through diagnostic tests information about patients that no other human being knows.

Second, the fiduciary nature of the physician/patient relationship means that patients entrust their health, lives, and personal information to physicians with the expectation this trust will not be betrayed. With at least an implicit promise, physicians who agree to provide care for patients also agree,

within reasonable limits, to preserve patient trust, promote patient preferences and protect patient privacy.

Third, the consequences of not being able to depend on confidentiality in physician/patient relationships would greatly damage those relationships. If patients were to conclude the information learned about them by their physicians could not be expected to remain with the physicians (and other health professionals with a need to know), they would (1) stop going to see physicians, (2) be less willing to provide medical and other relevant information about themselves and (3) be more inclined to refuse diagnostic procedures.

Breaching confidentiality

Physicians are sometimes morally justified in disclosing important information about a patient to another party without the patient's consent in order to meet their moral obligations to other persons. The ethical criteria for breaching confidentiality consist of these tests:

- one or more specific persons (not others in general) are at risk for harm,
- the harm is likely and would be significant,
- the disclosure to that person or those persons will probably prevent the harm,
- disclosure by the physician to the other person(s) is the only way (a moral last resort) to prevent the harm, and
- the disclosure is limited to the amount and kind of information necessary to protect the other person(s).

In addition, the requirement of confidentiality can be overridden by law, through mandatory reporting statutes of various kinds: vital statistics, contagious/communicable diseases, suspected child abuse (or elder abuse) and injuries that may have been criminally inflicted.

Dr. Weir is director of the program in biomedical ethics for the University of Iowa College of Medicine.

Practice and Personal Management

Management consultants and the group practice

Use of Management consultants in the group practice has become more common with the proliferation of health care reforms and managed care and growing pressure regarding the cost of health care. Even the most successful practice can benefit from an outside consultant. It is often more cost effective to rely on the occasional services of a management specialist than to maintain that ongoing expertise within your own organization. A good consultant can often bring a perspective, based on experiences with other practices similar to yours, that is difficult to obtain on your own.

When to use a consultant

Looking for help in the middle of a crisis is always less effective than planning ahead. Seek out a consultant early—when you first see a need for a major evaluation of your practice's patterns or when the practice is considering a major change. A good consultant addresses the overall issue or concern and formulates a plan which is carried out by the group.

Practice management consultants specialize in one or more areas. If your needs cover multiple issues you may see more benefit from use of a firm with a pool of professionals. Rarely can a single individual provide expert advice on such diverse issues as computerizing your appointment schedule, auditing your documentation or overhauling your benefit structure. A coordinated effort by a consulting team can also be more cost effective than using separate firms, since much of the expense associated with consulting services comes from the time and effort spent in becoming familiar with practice dynamics.

The author, Robert Poetting, is clinic manager of the Burlington Area Family Practice Center, and former senior provider automation consultant with Blue Cross and Blue Shield of Iowa. He is a member of the Iowa Medical Group Management Association.

The goal? Results!

Beware the consultant who brings his/her own agenda. Medical management consulting is a highly competitive business. Consultants are often affiliated with organizations having interest in providing other functions such as computer services or accounting. There is nothing inherently negative about these arrangements (many clients want and need the services) provided the consultant's focus is on producing results for *your* goals.

A successful consulting arrangement places emphasis on how your practice can best accomplish goals on its own. The consultant should help you structure the change—not do it for you. Success is gauged by the practice's ability to accomplish sustained results without creating an ongoing dependency relationship with the consulting firm. Follow-up services should be available, but they should be periodic and temporary. Be wary of the consultant who seeks to extend the relationship until all problems are solved.

Recognize the need

Too often, a stigina is associated with a management consultant, as if the physician or manager is expected to have all the answers without seeking assistance. As modern medicine relies on a team approach to critical patient care, the modern practice must also use a team approach to maintain its health in times of crisis or transition. The efficient practice makes wise use of all available resources and can seldom afford to "reinvent the wheel."

The consultant's value is partly derived from previous exposure to problems and needs that are new to you. The consultant's past experience with similar situations, combined with your familiarity and insight of your own practice, completes the team.

Choose wisely

While effective consulting usually comes with a price tag, returns are often multiple if the right person is matched to the right task. A poor choice can lead to new problems. Make your selection very carefully. Verify past performance independently. If the prospective consultant gives you a list of satisfied clients, check with those practices that are most like your own. Also ask if the client is aware of other clients having recent experience with the consulting firm and follow up with them as well. Ask specific questions and listen for any weak response.

Resource for change

A management consultant can provide a needed resource to facilitate change. Look to the consultant as an effective resource to compliment your effort, with an objective of reaching and sustaining your practice's goals on your own. Finally, the value of management consulting is enhanced when you include a common sense approach to planning, selection, results orientation and teamwork.



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Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventroilad rysfunction if they are receiving a beta-flocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally oroduce hypotension. Elevations of liver enzymes have been reported. Several cases have been comonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on vera, amil is prudent. Some patients with paroxymarial and/or chronic atrial flutter/fibrillation and ancec-sory Aft pathway (eg. WPW or LGI. syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil for digitals. Because of this risk, oral verapemil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, De 8%). Devia imment of market 15-trainee holds or progression to 2nd- or 3rd-degree. De 38%. Devia imment of market 15-trainee holds or progression to 2nd- or 3rd- or 3rdof this list, of a vergorian is contrainticated in such patients. Avidook may occur (zinc) and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd- degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd. legree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some chically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular verapami may eucreare ineutronscuare inscriminant placetimes must publicate description and profession combined therapy with beta-adrenergic blockers and verapamil may result in additive negal see effects on heart rate, autoventricular conduction and/or cardiac contractility, there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atendiol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% ouring the first week of therapy, which can result in digitalis roxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully

References: 1, Data on file, Searle, 2, Edmonds D, Würth JP, Baumgart P, et al. References: 1. Data on file, Searle. 2. Edmonds D, Würth JP, Baumgart P, et al. Twenty-four-hour monitoring of blood pressure during calcium antagonist therapy, In: Fleckenstein A, Laragh SH, eds. Hypertension—the Next Decade: Verapamil In Focus. New York, NY: Churchill Livingstone; 1987-94-100. 3. Middbo KA. Effects of Iong-term verapamil therapy on serum lipids and other metabolic KA. Effects of Iong-term verapamil therapy on serum lipids and other metabolic et al. Antihypertensive and renal effects of enalapril and slow-release verapamil et al. Antihypertensive and renal effects of enalapril and slow-release verapamil 5. Schmieder FM. Messerii FH. Garavagija Ge, s. d. activosyosium et verapamil in patients with essential hypertension. Creuation. 1987;75:1030-1036. 6. Midtbø K, Lauve O, Hals O. No metabolic side effects of long-term treatment with verapamil in hypertension. *Anglology*, 1988;39:1025-1029.

monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flicancier and verapamil may have additive effects on myocardial contractifity. AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomypathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of earon lithium labels or increased assections to influin. Patients requires both direct words. reported and any exact concordant destination of this control to the control to t increase the plasma levels of theophyline. Concomitant use of inhalation anesthetics and catalogues antagonists need careful tritation to avoid exceeding earlier depression. Verapami may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing) dosapami reduction may be required. There was no evidence of a cacrinogenic potential of verapamil earlier to a consideration of the control of the con

abou, and deniety only in ceasily records. Personal in Section 1 least should be discontinued during verganitude.

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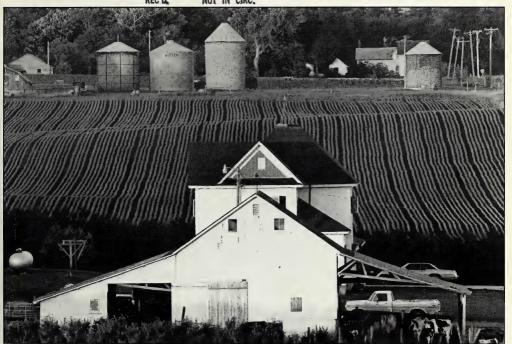
Journal of the Iowa Medical Society

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SPECIAL ISSUE: MANAGING AND TREATING OBESE PATIENTS

Expert says obesity is a 'chronic illness'

When should obese patients be treated surgically?

The road to heart disease sometimes begins in childhood

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About the Cover

The stunning photo of a farm north of Ames was taken by freelance photographer/writer David Thoreson. Thoreson, who operates his own poster and postcard company out of Okoboji, says he favors landscapes and that "the outdoors is my studio."

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President's Privilege



William Eversmann, Jr., M.D.

Not a solo but a chorus

THE FEDERAL GOVERNMENT—through the Health Care Financing Administration and with the help of Congress—has again created an environment for internal disagreement and discord within the ranks of the medical profession. No, it is not the PRO review hassle, it is called "zero sum game."

The zero sum game is a simple one. What one physician loses another physician gets. Zero sum occurs as we try to remove the 20% reduction in Medicare fees for new physicians. If new physicians are reimbursed at full fee, as they should be, all of the rest of the fees are reduced accordingly. Zero sum also occurs with EKG fees. If EKG fees are restored as they should be, all of our fees are reduced so the resultant sum is zero.

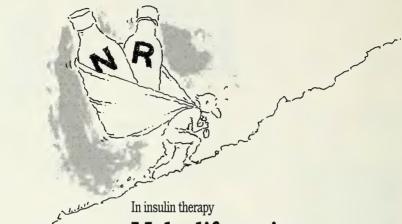
The zero sum game threatens our profession at a time when our professional unity could not be more fragile nor the possibility of fragmentation into special interest segments more damaging. Although the zero sum game can turn physician against physi-

cian or state against state, we must be aware that the profession which unites us in the care of patients is stronger than the elements that would divide us.

To deal effectively with those who would direct, manipulate, mold or destroy the medical profession, we must be united. We must have a concern for the profession. We must focus on the medical needs of our patients. We must educate the public about what is at stake. We must resist those who would change health care for purely ideological or economic reasons without adequate concern for patients or their care.

As we debate with those outside the profession, we must be of one voice; only within the profession can we debate, discuss, even argue the pros and cons of an issue. That single voice for the profession is vital whether dealing in the areas of worker's compensation, health care reform or legislation.

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The Editor Comments



Marion E. Alberts, M.D.

Legible medical records

The Handwriting analysts claim that our character is mirrored by the manner of our penmanship. The skills we demonstrate in word usage and sentence/paragraph structure present an insight to our command of proper writing skills. Nearly gone are the examples of beautiful penmanship skills of the Spencerian and the Palmer methods. Such penmanship is more commonly used on certificates and invitations.

You may wonder why am I engrossed in handwriting skills at this time. It is because of experiences I have endured during the past several months reviewing medical records. Much of the handwriting is atrocious and the typewritten records lack concise, orderly information. But, the handwritten ones are the real problem. There is much truth in the criticism often made by lay persons that physicians' handwriting is illegible. Yes, some have fine penmanship; others have scribbling that defies deciphering.

Getting back to those medical records ... it makes me wonder how often there are misconceptions of the content because it is poorly written. Scribbling the pertinent facts

of the history and physical findings in an illegible manner denotes to me two things: (1) carelessness, and (2) ill-conceived attempts to conserve time. Yes, I have been guilty of these charges as much as the next physician. For our own protection (i.e., the physician's) our records should be clear, concise, pertinent and inclusive of the facts at hand. I am sure lawyers take a good deal of delight in some records. Pity the records librarians who deal with them each day.

Doctors, it's no small matter. Some of your records are terrible! Develop good records, preferably typewritten. Keep all the data together so there is a smooth-flowing story of the patient's problems and concerns. Avoid fragmentation of various sections of the record. Develop a style and a form with complete information readily available without having to search for a laboratory report or a consultation letter.

A good medical record makes a statement: "This physician knows what is going on and has concern for the patient." Besides, it will help keep lawyers from drawing invalid conclusions about how you practice.

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- Medical Economics:
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- Occupational Lung Disease in Farm Workers
- Cardiac Syncope: A Problem of Presidential Proportion
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Guest Faculty

William E. Connor, MD
Professor, Department of Internal
Medicine, Head, Section of
Clinical Nutrition and Lipid
Metabolism, Oregon Health
Science University, Portland,
Oregon
Oregon

Presentation: Coronary Heart Disease—The Waxing and Waning of an Epidemic

Alan J. Garber, MD, PhD
 Professor of Medicine,
 Biochemistry, and Cell Biology,
 Baylor College of Medicine,
 Chief, Diabetes-Metabolism Unit,
 Methodist Hospital, Houston,
 Texas

Presentation: Hyperlipidemia in Diabetes: Adding Insult to Injury

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319/335-8598 for details.

Psychological management of obesity

Physicians will be more successful at managing obese patients if they view obesity as a chronic illness.

William Yates, M.D.

Iowa City, Iowa

DESITY REPRESENTS A MANAGEMENT challenge for physicians and a psychological and biological challenge for patients. Obese patients often look to their physicians for advice and care when they suffer the complications of severe obesity. Though physicians often look to their patients to modify lifestyle factors, emotional factors present a challenge.

Attention to the patient's psychological status is an important aspect of obesity management. The nature of chronic obesity and society's attitude toward obesity can produce psychological distress and adverse behavioral consequences. The obese often see their condition as a greater handicap than deafness, dyslexia or blindness. This can promote significant psychological distress and increase the risk of developing a psychiatric disorder. The morbid obese patient is at risk for affective, anxiety and substance abuse disorders.

Although the link between obesity, depression and anxiety disorders is not fully understood, possible psychiatric comorbidity should be considered. Patients should be questioned about their moods and whether they experience significant anxiety. Alcohol abuse or dependence, binge eating and bulimia nervosa should also be ruled out.

A treatment challenge

Treating comorbid depression in obese patients can be a significant challenge. Many of the tricyclic antidepressants increase appetite and promote weight gain. More recently introduced antidepressant medications have fewer adverse effects and provide a more satisfactory method for treating depression in obese patients. Studies of fluoxetine (Prozac) at 60 mg per day suggest a significant weight-loss effect of about 15 kilograms occurring over the first 20-28 weeks of administration.

The role of fluoxetine in long-term weight control is less well known. Stimulant medications such as dextroamphetamines that suppress appetite have no role in the management of obesity or depressive symptoms associated with obesity. Depression can also occur during periods of weight loss. Monitoring mood during successful weight loss can identify development of significant depression.

A key step to successful treatment of obese patients is to demonstrate a respect for the individual that has nothing to do with the patient's weight or success at losing weight. One way to promote acceptance of the obese patient is to identify obesity as a clincial problem for attention, study and possible intervention. This problem does not devalue the patient as an individual or person. Respect for the obese patient is not a minor issue. A survey of severely obese individuals

(Continued next page)

Dr. Yates is an associate professor of psychiatry at the University of Iowa College of Medicine.

found nearly 80% reported being treated disrespectfully by the medical profession due to their weight.

Patients feel guilty

Because many obese patients often feel responsible for their problem, physicians should avoid strategies that place blame or promote guilt. Threatening patients about medical consequences is unlikely to result in better diet compliance. Following unsuccessful weight loss attempts, it is best to accept the failure as a clinical challenge rather than an opportunity to blame or accuse.

Obese patients should receive realistic information about treatment options from their physicians. Quick loss "cures" abound in the press, magazines and television commercials. These unrealistic programs often promote false hope that can lead to a sense of loss when the unrealistic outcomes are not achieved. Demoralization can result from repeated unsuccessful attempts to lose weight. Physicians should not add to this burden by providing undue optimism. Patients should be told obesity is a tough clinical problem and the chances of long-term significant weight loss are small.

Another key to successful long-term management of obesity is to encourage the patient to set several health goals in addition to weight loss. Body weight involves significant genetic and biological determinants which are resistant to dietary change. Multiple target goals in addition to weight-loss can provide a sense of improvement and progress when weight reduction hits a plateau. Additional goals can involve aspects of obesity that may respond to attention when weight does not. Examples include: increasing exercise, reducing calories from fats and simple carbohydrates, improving the serum lipid profile, decreasing blood pressure or improving marital, occupational and social functioning.

Preoccupation, stress, avoidance

Obese patients often become preoccupied with their obesity and this can result in significant distress and avoidance behavior. One psychological approach to obesity management is to decrease the time thinking about weight, food and dieting. Distraction techniques such as exercise, reading or activities

TABLE 1

PRINCIPLES OF THE PSYCHOLOGICAL MANAGEMENT OF OBESITY

- 1. Monitor and treat psychiatric comorbidity
- 2. Treat the patient with respect
- 3. Accept weight gain (or failure to lose) as a clinical challenge
- 4. Discourge unrealistic expectations
- 5. Encourage non-weight based health goals
- 6. Decrease preoccupation with weight, weight loss, and dieting
- 7. Limit social, marital and occupational impairment
- 8. Use obesity-related visits as motivation opportunities
- Develop a chronic disease approach with attention to acute care, maintenance and relapse phases

with friends can reduce preoccupation with obesity and resulting distress. Obese patients often procrastinate or postpone life activities until a future time when they will have lost their excess weight. Patients should identify how they would change their lives if they were normal weight and then be encouraged to begin making those changes independent of successful weight loss.

Physicians may become frustrated with obese patients who do not seem motivated to lose weight. Physicians must realize they have limited control over a patient's motivation. A physician's efforts to increase motivation to lose weight may be most effective when patients seek care for an obesity-related problem. For example, non-threatening encouragement to begin a weight-management program may be more successful during a visit for knee pain secondary to osteoarthritis than during a routine physical when the patient is asymptomatic.

Psychological and medical management of obesity is a lifelong issue. Obesity should be viewed as a chronic disease. For chronic diseases, a goal of management rather than cure is necessary. Prevention of secondary complications becomes an important priority. Chronic illnesses require attention to the phases of acute care, maintenance and relapse. A psychological approach emphasizing patient respect, attention to psychological distress, realistic optimism and patient acceptance independent of weight factors is likely to promote successful management of the obese patient.

References

References noted are available from the author or the editors of *IOWA MEDICINE*.

Beware the 'quick and easy' diet

(Note: This information was provided by the Office of Consumer/Business Education of the Federal Trade Commission.)

A RE YOU LOOKING FOR A way to lose weight quickly and easily? You may be tempted to try one of the widely advertised weight-loss programs that use liquid diets, require special diet regimens or claim to have medically-qualified staff.

Before you pay for any weight-loss program, take note: while many diet programs may help you lose weight, there is little published evidence that most people maintain the weight loss for any significant time.

Being obese has serious health consequences. Some experts suggest that losing even 30% of excess weight can significantly reduce some obesity-related consequences.

If you want to lose weight permanently, scientific evidence suggests it is important to make lifelong changes in how you eat and exercise. The Council on Scientific Affairs of the American Medical Association says that only through gradual, long-term changes like these can you effectively lose weight and keep it off.

Be skeptical, then, of programs that promise quick or permanent weight loss. Such loss is likely to be short-term.

Dieting is big business

Dieting in America is a multi-billion dollar industry that caters to about 34 million overweight adults. To lose a pound of weight, you must reduce caloric intake or increase caloric demand by 3,500 calories.

To help dieters, many professional weight control programs offer special dietary and exercise plans, plus psychological support. Many such programs are operated through local hospitals, clinics and physician specialists. Two of these programs are:

Very low calorie (VLCD) programs, which use 400-800 calorie-a-day liquid formulas as part of a 12-16 week supplemented fast. Available only through physicians or hospitals, VLCD programs require constant medical supervision.

Most VLCD programs are for people who are severely obese, about 30% or more above their body weight. Typical loss may be around three to five pounds per week. VLCD programs cost about \$2,000 but may be partially reimbursed through insurance.

The second type of program is diet clinics/food plans. Many of these programs are 1,000-1,500 calorie-a-day diets where loss averages one or two pounds a week. You usually follow a carefully-controlled menu. You may be required to purchase packaged meals available only from the company and not reimbursable through health insurance. The costs of these programs vary from \$250 to \$1,000 or more. Be wary of initial low-price offers that may not include all the costs.

Health consequences of obesity

Complications of obesity can include increased risk of heart disease, stroke, high blood pressure, diabetes, gallstones, some forms of cancer and other illness.

Losing weight can help reduce these risks. In general, the more slowly you lose weight and the longer you maintain that weight loss, the safer that diet will be for you.

But, dieting itself is not without risks. Studies have reported that patients on VLCD or other rapid-weight loss plans may run an increased chance of developing gallstones. Less severe consequences of dieting include: dizziness, diarrhea, constipation, fatigue, muscle cramps, bad breath, temporary hair loss, headaches, potassium deficiencies and irregular menstrual cycles.

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Coronary disease prevention should begin in childhood

A panel of experts believes the process which often leads to heart disease actually begins in childhood with eating habits and high cholesterol.

Ronald Lauer, M.D.

Iowa City, Iowa

THERE IS COMPELLING EVIDENCE the artherosclerotic process begins in childhood and slowly progresses into adulthood, at which time it may lead to coronary heart disease, the major cause of death in adult Americans.

This is the conclusion contained in a recently published report from a panel of experts including epidemiologists, family practitioners, lipidologists, nurses, nutritionists, pediatric cardiologists and pediatricians. The panel was convened by the National Heart, Lung and Blood Institute to study the significance of cholesterol levels in children and adolescents.¹

The panel concluded that atherosclerosis or its precursors begin in childhood; that elevated cholesterol levels early in life play a role in development of adult atherosclerosis; that eating patterns and genetics affect blood cholesterol levels and coronary heart disease risk; and that lowering levels in children and adolescents will be beneficial.

While cholesterol is the focus of the report, other risk factors for atherosclerosis begin their influence during the pediatric years, the panel concluded. Specifically, cigarette smoking should be discouraged. Hypertension and its precursors should be treated. Obesity should be avoided or minimized.

Regular exercise should be encouraged and diabetes mellitus should be diagnosed and treated.

The panel recommended two complimentary approaches to lower blood cholesterol levels in children and adolescents: a population approach and an individualized approach. The population approach was recognized as the principal means for preventing coronary heart disease. The goal is lowering blood cholesterol levels in children and adolescents through changes in nutrient intake and eating patterns. The advantage of this approach is that even a relatively small reduction in cholesterol levels in childhood, if carried into adult life, could substantially decrease the incidence of coronary heart disease. Nutrient recommendations intended for all children and adolescents over the age of two years were:

 Nutritional adequacy should be achieved by eating a wide variety of foods.

 Energy (calories) should be adequate to support growth and development and reach and maintain desirable body weight.

 Total fats—an average of no more than 30% of calories; saturated fatty acids—less than 10% of total calories; dietary cholesterol—less than 300 mg per day.

These recommendations are directed to parents and children, schools, health professionals, government agencies, the food industry and to the mass media who influence children's food selections.

(Continued next page)

Dr. Lauer is with the U. of I. College of Medicine, Department of Pediatrics, Division of Pediatric Cardiology.

Identify children at risk

The goal of an individualized approach is to identify children who are at greatest risk of having high blood cholesterol as adults and increased risk of coronary heart disease. The panel recommended selective screening of children and adolescents who have a parental or grandparental history of premature (<55 years of age) cardiovascular disease or a parent with high blood cholesterol (>240 mg/dL). The panel focused on these young people because of the strong evidence demonstrating a familial aggregation of cardiovascular disease, high blood cholesterol as well as other risk factors.

Many children and adolescents may not know their family histories. Physicians and other health professionals have a special responsibility for identifying those at high risk, and may choose to measure cholesterol levels in children and adolescents whose parental and grandparental histories are unobtainable, particularly in children who have other risk factors.

Universal screening

Before recommending this selective screening approach, the panel carefully considered the advantages and disadvantages of universal screening. The principal advantage of universal screening is its potential to identify all children with high cholesterol levels. However, the panel concluded there is insufficient evidence to support universal screening. Universal screening has certain disadvantages. Although high cholesterol levels in childhood are often associated with high levels in adulthood, in many cases this is not true, making tracking imperfect.^{2,3}

In addition, the panel was concerned that as a result of universal screening, a large number of children would be categorized as patients who require individual counseling. This could provoke unjustified anxiety in children and their parents, including many children who would turn out not to have high cholesterol levels as adults, even without intervention. For most children who have high cholesterol, a diet low in saturated fat and cholestrol is sufficient; only when hypercholesterolemia is more marked are specific medical interventions justified.

Another concern of the panel was that the introduction of universal screening would lead to overuse of cholesterol-lowering drugs. Insufficient evidence exists about the safety or efficacy of drug therapy in childhood and adolescence to reduce CHD morbidity and mortality in adulthood. The panel believes such drug use should be held to a minimum.

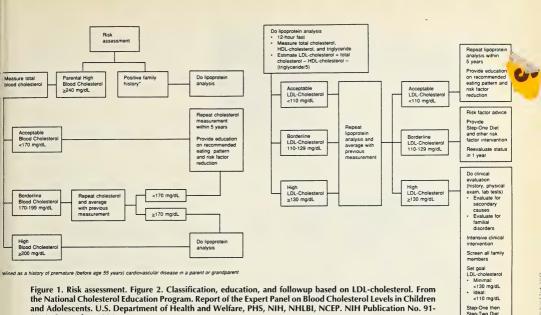
Finally, while pathologic lesions may currently be common in childhood, they are low grade and unlikely to cause clinical sequelae for many decades. 4.5 Coronary heart disease deaths for the most part occur after 65 years of age.6 Given the efficacy of medical intervention in middle-aged hypercholesterolemic individuals, there is sufficient opportunity to introduce medical treatment for most individuals some time in adult life.7,8 Although it did not recommend universal screening, the committee agreed that for very high risk hypercholesterolemic children (those with a family history of premature cardiovascular disease or familial hypercholesterolemia) it is prudent to initiate treatment at an early stage (Figures 1 and 2).

It was recommended that children with a parental history have their cholesterol measured; LDL-cholesterol should be measured in those with a family history of premature atherosclerotic disease. Acceptable levels of total cholesterol and LDL-cholesterol levels for children whose families have a history of premature cardiovascular disease or hypercholesterolemia are:

Category	Total cholesterol	LDL-cholesterol
Acceptable	<170 mg/dL	<110 mg/dL
Borderline	170-199	110-129
High	>200	>130

Children with acceptable levels should be evaluated again in five years. Children with borderline levels should be reevaluated in a short time. If their average levels are elevated, LDL-cholesterol should be measured. Those with borderline elevated total cholesterol and LDL-cholesterol should receive individualized dietary advice. Their LDLcholesterol should be repeated in one year.

Those with persistently high levels of LDL-cholesterol should be evaluated for secondary causes of familial disorders that can cause cholesterol elevations. If the hyperlipidemia is not secondary, individualized dietary instruction should be given. If this does not sufficiently reduce cholesterol levels, it may be necessary to restrict the amount of saturated fatty acids to less than 7% of calories,



total fats to less than 30% of calories and cholesterol intake to less than 200 mg/day.

2732, September 1991.

Drug therapy was recommended only in children over the age of 10 years if, after an adequate trial of diet therapy (six months to one year), the LDL-cholesterol exceeded 190 mg/dL; or if LDL-cholesterol exceeded 160 mg/dL and there is a positive family history of premature cardiovascular disease before the age of 55 years; or if the LDL-cholesterol exceeded 160 mg/dL and two or more other cardiovascular risk factors are present. Other risk factors include cigarette smoking, elevated blood pressure, low HDL-cholesterol (<35 mg/dL), severe obesity, diabetes mellitus and physical inactivity.

These recommendations provide a definition of preventive pediatric cardiology practices. Pediatricians, nurses and nutritionists should identify and treat children from families at greatest risk for premature coronary heart disease. This effort could be facilitated if physicians and other health care professionals who care for adults with premature coronary heart disease or hypercholesterolemia arrange for the children of these patients to be examined.

However the greatest role in prevention is in the provision of education, environments and foods that will encourage all children and adolescents to consume less total fat, saturated fat and cholesterol in their daily nutritional intake. This latter role is one physicians can encourage in their discussions with parents, children and adolescents.

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IOWA MEDICINE Interview



Linda Snetslaar

A nutritionist discusses obesity

Physicians will find more success with obese patients who have multiple goals other than weight loss, says this nutritionist with the University of lowa Hospitals and Clinics Department of Internal Medicine.

How do you define obesity?

Obesity is a pathologic condition characterized by an accumulation of fat much in excess of that necessary for optimal body function. As such, it is distinct from "overweight," which is defined as body weight much in excess of average.

Both these definitions are imprecise from physiologic and anatomic viewpoints. For example, populations which are subjected at regular intervals to scarcity of food may consider a certain measure of obesity desirable or necessary for survival. The definition of overweight given above makes no mention of body type. A professional football player may be muscular and lean at a weight which would be clearly excessive in a physically inactive executive.

The careful physical examination of the patient is important. Visual judgment of an experienced observer is a reliable method of

determining the need for weight loss. Height and weight tables are important in determining the degree of obesity or overweight. In children with constant increases in height, care should be taken in examining height and weight tables to assure weight loss is appropriately recommended. Obviously we need quantitative data on both obesity and overweight if we are to carefully relate weight and fat content to disease in population groups.

National studies show lowa has a comparatively large percentage of overweight people. Why is this true?

There may be physiologic reasons which, when treated with medications, reverse. However, in most cases it is a simple matter of consuming more calories than are expended. Perhaps Iowans are adhering to past eating habits designed for surviving the hard work of farming. Modern conveniences have

replaced many labor intensive farming methods. The lack of caloric expenditure and little change in dietary intake may be one reason for the high incidence of overweight Iowans.

Do you believe in dieting?

I believe in a decrease in total caloric intake, but it is difficult to lose weight only through calorie intake reduction. I always recommend a routine exercise program.

How many overweight people got that way because of genetic factors?

It is well established that obesity "runs in families." In a series of over 1,000 obese patients in Vienna, one or both parents were obese in 73% of cases. This figure is close to the 69% found in a series of 250 patients in Chicago.

What are the components of a nutritious diet?

A nutritious diet contains small amounts of fat with adequate nutrients from fruits and vegetables. Low fat meats remain low in fat if they are broiled, roasted or pan fried with non-fat spray coating. Whole grain cereals, breads, pastas and fat free or 1% fat dairy products are also low in fat.

What should physicians do for patients who are moderately overweight, perhaps 25-30 pounds?

A starting point is to introduce a routine exercise program. The next step is to evaluate the diet for fat content and modify the diet to achieve a palatable intake with reduced fat.

Do physicians do a good job of managing overweight patients?

Those physicians who recommend weight loss through a plan of exercise (caloric expenditure) and decreasing dietary calories will achieve the greatest success. When diet is the only target, weight loss will be slow and many patients will become discouraged.

LETTERS TO THE EDITOR

If you have a comment regarding something you've read in IOWA MEDICINE or an observation on conditions affecting the practice of medicine in Iowa, don't keep it to yourself. Share your thoughts in a letter to the editor. We'd like to hear from you.

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Clinically severe obesity—a review

Gastrointestinal surgery is indicated for some severely obese patients. These two experts discuss guidelines for evaluating potential candidates.

Cornelius Doherty, M.D. Edward Mason, M.D.

Iowa City, Iowa

FOUR MILLION AMERICANS have body mass index (BMI) between 35 and 40 and another 1.5 million have BMI over 40. According to Colditz, "the sum of the costs attributable to obesity for the disease conditions reviewed is \$39.3 billion, which represents 5.5% of total cost of illness in 1986."1 The BMI associated with the lowest mortality is between 20 and 25 kg/m.²

Clinically severe obesity (this term is now preferred over morbid obesity) is a disease of excess energy storage in the form of fat. Clinically severe obesity correlates with a BMI of 40 or 100 lbs overweight. The risk of morbidity and mortality accompanying obesity is propor-

tional to the degree of overweight.

The biologic basis for obesity remains unknown. The fundamental mechanism is an imbalance between caloric intake and energy expenditure. The contributing causes are environmental, cultural, socioeconomic and psychological. The physiologic, biochemical and genetic evidence is overwhelming that clinically severe obesity is not a simple disorder of willpower, as sometimes implied, but is a complex disorder of energy metabolism that is chronic and frequently progressive. The majority of the obese experience the onset of the condition between the ages of six and 20.

Cultural bias against fat

An additional burden of severely obese people is discrimination from a lipophobic culture. The severely obese are victims of misunderstanding, prejudice and bias. They are blamed for their disease. They are aware that others view them with contempt and repulsion. They do not have greater levels of psychopathology.

However, some obese people have severe personality dysfunction and some have special problems with body image disparagement. Many experience significant anxiety and depression and know there is no cure for severe obesity. They experience diminished access to treatment. They fear immobility, isolation and abandonment. They have failed repeatedly at non-operative weight management; many have lost large amounts of weight only to regain it. They need treatment to sustain a medically significant weight loss and help them control food.

The National Institutes of Health in 1985 and 1991 commissioned an evaluation of the health implications and treatment of obesity. In 1985 the health implications of obesity were accepted as increased risk for cardiovascular disease (especially hypertension), dyslipidemia, diabetes mellitus, gallbladder disease, in-

Dr. Doherty and Dr. Mason are general and gastrointestinal surgeons with the University of Iowa Hospital and Clinics.

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creased prevalence of selected types of cancer and socioeconomic and psychosocial impairment.² A further conclusion was that weight reduction may be life saving for persons with extreme obesity. Extreme obesity was defined as twice the desirable weight or 45 kg (100 pounds) greater than desirable weight. When obesity is accompanied by severe cardiopulmonary insufficiency, as in the Pickwickian syndrome, weight reduction should be part of the treatment for this medical emergency.

Guidelines for surgery

In 1991, a statement on gastrointestinal surgery for severe obesity included the following:³

- Although acceptable weight reduction may be achieved, a major drawback to the nonsurgical approach is failure to maintain reduced body weight in the vast majority of persons.
- All treatment options should be discussed. Candidates for surgery should be those judged by experienced clinicians to have a low

'The physiologic, biochemical and genetic evidence is overwhelming that clinically severe obesity is not a simple disorder of willpower.'

probability of success with nonsurgical measures demonstrated, for example, by failures in established weight control programs or reluctance to enter such a program. A gastric restrictive or bypass procedure should be considered only for well-informed and motivated adults with acceptable operative risks. The patients should be able to ensure participation in treatment and long-term follow-up.

Persons whose BMI exceeds 40 may be considered candidates for surgical treatment if they strongly desire substantial weight loss, because obesity impairs the quality of their lives. They must demonstrate realistic understanding of how their lives may change after the operation.

In certain instances, less severely obese persons (BMI, 35-40) also may be considered for surgical treatment. Included among these are persons with high risk comorbid conditions such as life-threatening cardiopulmonary conditions (e.g., severe sleep apnea, Pickwickian

syndrome and obesity related cardiomyopathy) or severe diabetes mellitus. Other possible indications include obesity-induced physical problems causing significant interference with lifestyle (e.g., joint disease that would be treatable were it not for the presence of obesity or body size problems precluding or severely interfering with employment, family function or ambulation).

• Issues of efficacy and risk in bariatric surgical procedures must be evaluated with the acknowledgment that severe obesity is a chronic intractable disorder; any therapeutic program must, therefore, be lifelong in its application. Although definitive therapy is not currently available, surgical procedures now in use can induce significant weight loss in severely obese persons. This in turn has been associated with amelioration of most of the comorbid conditions that have been studied.

 Available published series report that the immediate operative mortality rate for both vertical banded gastroplasty and Roux-en-Y gastric bypass is low.

Evaluating weight loss programs

In 1992, the National Institutes of Health convened a technology assessment conference and released a statement on methods for voluntary weight loss and control.4 The recommendation was that one should not be distracted by anecdotal "success" stories or by advertising claims when evaluating weight loss programs. The information that should be obtained about the program includes: the percentage of all participants starting the program who complete it; the percentage of those completing the program who achieve various degrees of weight loss; the proportion of that weight loss that is maintained at one, three and even five years; the number of participants who experienced negative medical effects, their type and severity.

These comprehensive peer reviews by the National Institutes of Health give clinicians the current information on the health implications of obesity and the options and outcomes of treatments for severe obesity. With these resources, clinicians can competently counsel patients.

The concept of gastric restrictive surgery was first developed in the experimental laboratories of the University of Iowa Hospital and Clinics 25 years ago by Mason & Ito. The initial operation was the loop gastric bypass. In 1980

the vertical banded gastroplasty (VBG) was introduced, also at the University of Iowa.⁶ This operation provides a small food-receiving pouch with a measured volume of 13 ml at 70 cm of water. A collar of polypropylene mesh stabilizes the outlet channel of the pouch at a calibrated diameter of 11 mm to prevent dilatation.

Vertical banded gastroplasty provides early satiety and limits the volume and the rate at which solid food can be ingested. The gastro-intestinal tract is not bypassed and digestion and absorption are undisturbed. Although the total amount of excess weight lost and deterrence to sugar ingestion with VBG is less than with the gastric bypass procedure, VBG is the operation of choice at University of Iowa Hospitals and Clinics because of low mortality and freedom from the complications of blind segments of the digestive tract, malabsorption and dumping.

VBG provides stabilization of the outlet channel, easy access for endoscopic and radiologic examination and reversibility. The rate of leakage and peritonitis for VBG during the first decade of use had been 0.6%. The operative mortality has been 0.24%. This represents a 10-fold reduction from the leak and mortality rates observed during the early years with gastric bypass. The reoperation rate has been 1.4% per year for the first five years after VBG.

The definition of success is the loss of at least 25% of preoperative excess weight without a reoperation. Follow up data of 313 patients at five years revealed success in 78.6% of patients. The failure group of 21.4% included 15.3% who sustained a loss of less than 25% of excess weight and 6.1% who required a revision. These data clearly demonstrated that VBG results in significant sustained weight loss at five years after operation in the large majority of severely obese patients.

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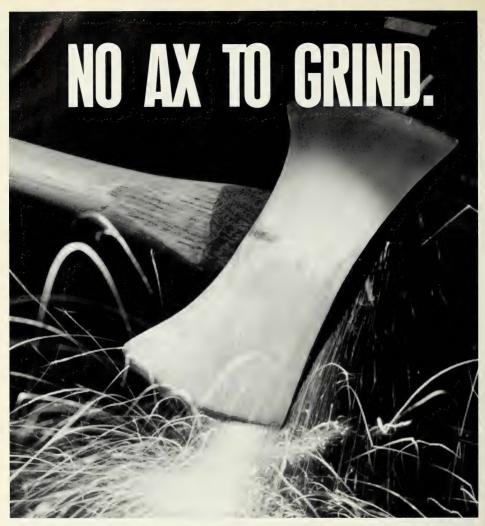
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Community-based CME

Richard Nelson, M.D.

CONTINUING MEDICAL EDUCATION OCCURS in varied settings, from the amphitheaters of academic medical centers to the ball-rooms of convention hotels, within hospital staff meetings and via audiotape in an automobile. An option of increasing interest to the physician is the availability of CME in the community.

Community-based CME offers several advantages. Program content can focus on issues of relevance to physicians in the community as determined by an assessment of their educational needs. (For example, physicians in a community with a high incidence of occupation-related conditions may require a review of the management of those conditions.) Changing standards of practice and the availability of new technologies provide additional reasons for community programs.

The community also provides considerable flexibility in the format of programs. Early morning, midday, evening and Saturday sessions are possible, as are sequential programs on related issues over weeks or

months.

In Iowa, community Category I CME programs can be sponsored through community hospitals accredited by the Iowa Medical Society or through joint sponsorship offered by a hospital or specialty society with the U. of I. College of Medicine. During 1991, 123 programs were jointly sponsored by the U. of I.

Some physicians utilize CME events in their communities to learn of advances in health care from visiting university faculty and specialists from other major medical centers. Community-based CME also gives physicians the opportunity to learn from one another. Clinical-pathological conferences often feature community colleagues.

Probably the greatest challenge in organizing community-based CME is the selection of program topics and formats. Too often, programs are based upon the interests of the planner or an isolated request. While such programs may provide an excellent learning experience for participants, too often they fail to engage adequate numbers of physicians.

There is a better way. The chief of staff of a community hospital or county medical society officer should survey physicians and other professionals within the community concerning possible programs, speakers and formats. The survey should offer the option for listing desired topics. Often neglected in this process is input from others in the community involved with health care. Hospital and nursing faculty administrators, school personnel, public health nurses, lawyers and business personnel managers may also provide suggestions.

Recommendations for presenters should also be solicited in the survey. The CME planner should be alert to anyone in the com-

munity who could be involved.

Formats which vary from the usual lecture-discussion can stimulate interest among participants. Introductory case presentations, discussion of the issue by a specialist who consults in the community and a panel discussion are options.

Encourage presentors to utilize outlines and audiovisual aids. Begin and conclude programs as advertised. Do not avoid controversy. If medical knowledge were not in continuous transition, there would be no need for CME!

Dr. Nelson is associate dean for continuing medical education at the University of Iowa College of Medicine.

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Syncopal episodes: reducing future risks

A 73-YEAR-OLD female was admitted to the hospital after suffering an apparent syncopal episode at home. The patient had fallen, striking the base of her neck. According to the nurse's admission record, the patient felt fine, went outside and blacked out. The patient was vague and somewhat amnesic; she did not complain of headache or chest pain.

An EKG showed sinus bradycardia. No carotid bruits were auscultated, according to the ER record. The patient was monitored with telemetry and Corgard 40 mg, one tablet daily was prescribed by the physician on July 15. The nurse's admission record listed Corgard 40 mg daily as one of the patient's present medications. On July 17, a carotid ultrasound was performed and showed minimal carotid plaque bilaterally with no hemodynamically significant stenosis.

In a July 19 progress note, the physician stated that a stress test was negative and that the patient was to continue taking the Corgard. The patient was discharged that day.

Reviewer comments

The patient's H&P was dictated on July 16. According to the discharge summary, HEENT were negative. However, according to the H&P, the physician failed to perform a neurological exam or an examination of the patient's head, eyes, ears, nose or throat (HEENT).

The patient fell prior to admission due to an apparent syncopal episode. Therefore, it was imperative the physician perform a neurological examination on the patient to determine the etiology of the patient's symptoms. The physical exam must include a comprehensive examination of each body system with particular attention to the body system presented in the chief complaint.

This column was written by John Ellis, M.D., who specializes in internal medicine and geriatrics in Muscatine. He has served as an IFMC physician reviewer for two years and is presently chairman of the The physician should have performed and documented a neurological and a HEENT examination. The results of this evaluation should have been included in the H&P.

The nurse's admission record listed Corgard 40 mg daily as one of the patient's present medications. At the time of admission on July 16, the physician ordered Corgard 40 mg daily. The H&P listed syncope secondary to bradycardia or Stokes-Adams type syncope as the admitting diagnosis.

According to the nurse's admitting record, the patient had already taken her dose of Corgard on July 16 before the episode occurred. The medication record showed the patient received Corgard 40 mg on July 17

and 18 while hospitalized.

The patient was admitted with an apparent syncopal episode and with documented sinus bradycardia and a heart rate in the 48-50/minute range. Rhythm strips reflected periods of AV dissociation. In the presence of bradycardia and AV dissociation, continuing the beta blocker increased the patient's risk for further syncopal episodes. The physician should have stopped the Corgard while the

patient was in the hospital.

In his final progress note on July 19, the physician said the patient was to take Corgard 40 mg 1/2 tablet every day for one week, then 1/2 tablet every other day. It was inappropriate to discharge the patient on Corgard since the purpose of the admission was to determine the cause of the patient's syncope. The only way to determine if the syncope, bradycardia and AV dissociation were related to the Corgard was to discontinue the medication and monitor the patient. If necessary, an alternative blood pressure medication should have been used to treat the patient's hypertension.

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New members (as of January 15, 1992)

Kenneth Kilian, M.D., family practice, Keokuk

Prasad Mikkilineni, M.D., psychiatry, Keokuk

William Steele, M.D., dermatology, Washington

Jamal Hoballah, M.D., General surgery/ critical care, vascular surgery, Iowa City

Abdul Sarraj, M.D., internal medicine, Clinton

Michael Swanson, M.D., anesthesiology, Davenport

Julia Andreoni, M.D., internal medicine, pediatrics, Tipton

William Jones, M.D., neurology, Cedar Rapids

James Justice, M.D., internal medicine, Cedar Rapids

Mary Krob, M.D., general surgery/critical care, Cedar Rapids

Thomas Miner, D.O., family practice, Dyersville

Jonathan Ashton, M.D., anesthesiology,

Patricia Cantagallo, M.D., internal medicine, Cedar Falls

Annie Kontos, D.O., family practice,

Ming Chan, M.D., general surgery, Knoxville David Daining, M.D., internal medicine, Pella

Stewart Kanis, M.D., family practice, Pella

Dale VanderBroek, D.O., internal medicine, Pella

Nancy VanderBroek, D.O., general practice, Pella

Anthony Bottone, M.D., psychiatry/child psychiatry, Ottumwa

Riel Sarno, M.D., resident, Broadlawns Medical Center, Des Moines

Kevin Keefe, D.O., internal medicine, Ames Steven Allgood, M.D., general surgery, Mason City

Samuel Congello, D.O., invasive cardiology, Mason City

John Tagett, M.D., occupational medicine, Mason City

Sawat Phruttitum, M.D., general surgery, Charles City

Gerald Felt, M.D., urology, Council Bluffs Ernest Galbreath, D.O., resident, Cherokee Clinic, Cherokee

Keith Probst, M.D., family practice, Swea City

Jonathan Beeler, M.D., diagnostic radiology, Sioux City

Deceased members

LeRoy Ayers, M.D., 88, life member, obstetrics/gynecology, Sioux City, died June 8

Edward McMurray, M.D., 92, life member, family practice, New Sharon, died May 4

John Stokes, M.D., 54, cardiovascular diseases and internal medicine, Cedar Rapids, died May 30 Lowe Down n. the true pertinent facts; secret or inside information

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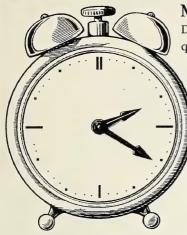
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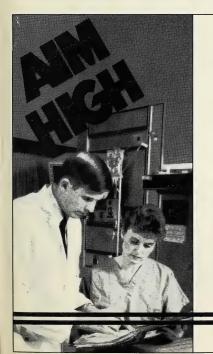


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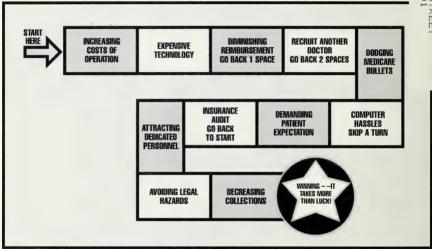
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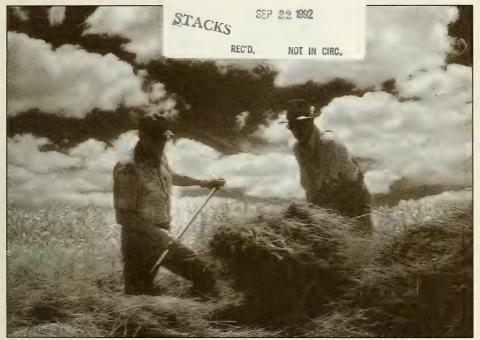
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Iowa Medicine

Volume 82 Number 9

Journal of the Iowa Medical Society

September 1992

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This timely fall photo entitled "Straw Men" was taken at Living History Farms by David Ramsey, administrator of lowa Methodist Medical Center, Des Moines. Mr. Ramsey is also an extremely talented photographer.

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President's Privilege



William Eversmann, Jr., M.D.

"Let George do it?"

If WE HAVE BEEN STARTLED by the events of the past year, we may be overwhelmed by the changes in the year to come. Within two months the federal House of Representatives will likely see a 25% change in its membership and at least 40% of the Iowa Legislature will be different. Such political change is rarely seen but this year is encouraged by reapportionment, recession and scandal.

At a time when significant proportions of our legislative bodies are newcomers, the subject of health care reform will be debated and some reforms enacted. Physicians have an opportunity and a responsibility to the public, our patients and these governing institutions to improve the health care delivery system through constructive reform.

Accordingly, each of us must develop our own detailed and extensive knowledge base on health care reform and having done so, communicate that information to our patients, legislators, office staff, colleagues, neighbors and friends. We must work to educate others and develop honest improvements that will benefit the public—our patients. We cannot discard, overlook or neglect

our moral commitments, our obligation to the profession, our integrity or our patients. We cannot be self-serving. We must discuss and illustrate the potentials and pitfalls of reforms. The public must know the implications and likely results of these decisions. Our patients must be involved. It is their health care which will be affected.

As I have indicated in previous columns, the importance of speaking with a single voice, one message, a unified response from physicians is vital. A subject of this complexity cannot be presented easily or understood in a single exposure. We must be persistent not only by expanding our own knowledge base but by offering our information again and again to others.

Iowa Medical Society officers and staff are preparing an informational campaign on health care reform and will be instrumental in the physician education process.

We can't leave this job to George! For you see, he may not have the morality, the integrity, or the patient's best interests foremost, let alone the knowledge or the experience of a physician.

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William E. Connor, MD

Professor, Department of Internal
Medicine, Head, Section of
Clinical Nutrition and Lipid
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Presentation: Coronary Heart Disease—The Waxing and Waning of an Epidemic

Alan J. Garber, MD, PhD
 Professor of Medicine,
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The Editor Comments



Marion E. Alberts, M.D.

Sticks and stones

HATE YOU! You're no damn good! Whap! Bam! I'll kill you!

Such a scene occurs far too often these days. Violence begets violence... "an eye for an eye, a tooth for a tooth." Family violence is a social problem that is not new. Tacitus, the Latin historian (c. 55-117 A.D.), declared: "Accerima proximorum odia;" "The hatred of relatives is the most violent."

Humans are strange creatures. Our intellect has loopholes that create emotional upheaval which often results in physical as well as mental violence. It has been with us and will continue; but, what can we do about it?

Every person who commits a violent act, be it in the public sector or within a family unit, cannot be incarcerated for the antisocial behavior. Violence can be controlled only by understanding and the provision of social standards above the level of snarling dogs and vicious wild animals. Behind the violence within a family is often a mixture of jealousy, deceit, lack of resources and too often the genetic makeup of some individuals. Poverty, broken home or, in some instances, a disparity between family members in life

successes can lead to distrust, doubt, despair and finally a physical outburst resulting in violence.

Our social structure is fraught with disunity; disunity in the total social structure as well as within the family unit. Hate and misunderstanding ensue . . . violence follows. What a horrible way to solve problems. Adult authority conflicts with children's rights; individual autonomy clashes with family solidarity; sometimes legal rights loom overhead. In some families the status of women conflicts with responsibilities as parents. An adult's position as an adult may differ with experiences as a child. Conflicts arise regarding loving one's child versus loving one's spouse.

There are so many factors that complicate family dynamics. Yet we must constantly keep in mind that the family is the basic unit of all of society. With so much family violence, it is no wonder that there are continuing national and international conflicts. The question has always been, and probably always will be, "Why can't we all live together peacefully?"

September 1992

Victims of family violence are everywhere, say Iowa experts

Family violence has become such a pervasive problem that every physician must be educated on how to diagnose and assist its victims. lowa experts discuss family violence, particularly child abuse and elderly abuse.

Editors' Note: The following are excerpts from presentations by Iowa experts in family violence which were given at the April IMS Scientific Session. The discussion was led by John Fernandez, M.D., a Council Bluffs psychiatrist. Presentations were given by Randell Alexander, M.D., a professor of pediatrics at the University of Iowa; Marno Mayer, program director for Iowa Child Protective Services; and Ronald Roth, M.D., a Waterloo family physician who serves as medical advisor for several long-term care facilities.

Introduction by Dr. Fernandez

There is a pervasive culture violence which permeates the lives of our patients. We physicians are on the front lines and see a tremendous number of victims.

Domestic violence is the second most common cause of injury in women of all age groups and the leading cause for women ages 15-44. It is more common than auto accidents, muggings and rapes combined. One of the recommendations being mentioned is that physicians should routinely ask in their history and physical questions about possible psychological and physical abuse.

Dr. Alexander: a refresher course in child abuse reporting

Every physician who engages in the primary care of children has to have two hours of

training in the identification and reporting of child abuse every five years. As an employer, you have to provide that training. That's one of the things in Iowa law that not everyone knows is there.

Iowa's original child abuse law said children are in urgent need of protection from physical abuse. It really wasn't until the 1980s that sexual abuse was dealt with from a child abuse perspective. It's always been possible to report neglect, and this is still our most common report. However, it's underreported because it's difficult to spot.

Iowa's child abuse laws are still more for victims than for potential victims. If threatening things have been said but the child hasn't actually been hurt, your report may be turned down. As a pediatrician I have a problem with the tendency to wait until something happens before the state intervenes.

Immunity for reporters of child abuse helps encourage reporting. Anyone reporting in good faith is immune from any civil or criminal liability. You can take photographs and x-rays without parental consent.

Also, in Iowa a physician can put a child in protective hold if you can't reach a judge or somebody else to do it. I can keep a child for up to 72 hours and by that time the court is supposed to hear the case. I will not get into trouble for doing this, though I might get scolded. Your hospital attorneys will tell

you they'd much rather a judge did this, but

sometimes emergencies come up.

Remember, if you have a nurse in a unit who says she wants to make a child abuse report, your job is to help her make that report. You may not agree with her, but it's her liability as an individual and it's her judgment call. No supervisor can tell you not to make a child abuse report.

When you make a child abuse report and the case gets to a court, you have to testify. Doctor-patient privilege is meaningless in the case of child abuse... you have to tell.

Making a child abuse report is always a safe thing. Not making a child abuse report can get you into trouble. I know there are county attorneys somewhere waiting for a case to come along where an example can be made of a good physician who blew it. You can be held responsible if you willfully don't make a child abuse report, in other words, you know it's a case of child abuse but you don't report it because you think you know the family.

'There often are no physical signs of elder abuse, you have to look for differences. You have to notice whether they seem happy.'

Also, you can be sued for failure to report child abuse. There have been multi-million dollar lawsuits in these cases and the same is true for dependent adult abuse and elderly abuse. These things tend to get settled for around a million dollars and it's not certain your insurance will always cover you.

One problem is that physicians worry there will be a loss of rapport with their patients if they make a report. However, having rapport is of no value when someone is being hurt. Talking with the family instead of reporting was tried for decades but it didn't work. You don't know everything about a family, you aren't in their home and you don't know what their lives are really like. Many times what we see going on medically is only the tip of the iceberg.

What if you make a child abuse report and nothing comes of it? There is an appeals process through the Department of Human Services. Don't deal with the supervisor to whom you made the original report — go at least one level higher. You can also approach the other parties involved — the county attorney and the judges. Tell them what the problem is and why you're upset that nothing has been done. They will probably be responsive — they respect our profession.

Continue to report new episodes involving the same child. Every time you make a report, don't miss new details not included in the other reports. It may add up to a pattern and eventually something will be done.

Don't forget your therapeutic mandate. No bones or bruises ever healed because of a legal process.

Marno Mayer: a child abuse report is the first step toward healing a family in crisis

One of the things Dr. Alexander stressed to you is the importance of making a report to the Department of Human Services if you suspect child maltreatment. The key word here is suspect. You don't have to prove the case before you make a report. Making a report doesn't mean you want the case to be substantiated, it simply means you want someone to look into it. Nearly 100% of people incarcerated for violent crime suffered physical abuse or neglect as children, so it couldn't be more important to recognize the symptoms and report it.

Besides physicians, other people in Iowa who are mandated to report suspected child abuse are social workers, foster parents, child care providers, law enforcement, school teach-

ers and mental health workers.

Iowa's child abuse statistics mirror national statistics. In 1990, we did 19,296 investigations; 8,251 Iowa children were determined to be victims of child maltreatment. Thirty-six percent of those were physically abused; 17% were sexually abused, 47% were denied critical care, which is the neglect category. There were 10 abuse-related child fatalities in Iowa in 1990. Teachers are the most frequent reporters of suspected child abuse, both nationally and in Iowa. About 10% of suspected cases in Iowa are reported by physicians.

When I have the opportunity, I always emphasize the importance of listening carefully to whether a story makes sense. I have

(Continued next page)

a wonderful example of a case which demonstrates to mandatory reporters that there can be victims of child maltreatment in middle or upper class families. When I was doing investigations, I received a case involving an 18month-old girl who had a very bad circular burn covering much of her foot. The mother was a registered nurse employed in a physician's office. She was a good mother, and had taken the child to the emergency room with the burn. The child had been in the care of a babysitter when the incident occurred. and the story the mother told in the emergency room was the only story she knew the story the babysitter told her. The sitter said the little girl climbed up onto the kitchen counter and stuck her foot into a pan of boiling water, then got down off the counter and became a little fussy.

The child was treated almost daily due to the severity of the burn and the person who finally made the report was the physician for whom the mother worked. He was not treating the child, but he knew the baby-sitter's story just didn't make sense. The people treating the child made a mistake because they knew the mother had nothing to do with the injury and thought that meant they

didn't need to make a report.

Many people feel guilty and uncomfortable making child abuse reports. They think the families will be angry and sometimes they are, but protecting the child is the overriding concern. Many times when a report is made it is really the first step for the child and the family to begin to get better. As professionals and as a society, we should view making a report and offering services to a family in a more positive light because it's truly meant to be that way.

Dr. Roth: 'minimal care' for elderly difficult to establish

For a long time we have been sensitive to the needs of children, but the elder abuse or dependent adult abuse issue came to our attention much later. Attention to what was called in the Canadian literature "Granny Bashing or Granny Battering" didn't occur until about 1975.

Health care professionals have a tendency to sympathize with people who are taking care of grandmother or grandfather because they can be difficult. We as health care professionals feel the caregivers are doing the best they can in a difficult situation. Also, we may be less sympathetic to elderly people than we are to a beautiful child who has been abused or an attractive young lady who has been beaten.

One major problem is experts really haven't been able to come up with exact standards to determine what is minimal care for grandmother or grandfather. Do we really know what an 85-year-old woman or man should look like? Part of minimal care for a child is bathing, but an older person can refuse a bath and there's nothing one can do about it. The patient can be perfectly competent but just refuses to take any more baths.

One of the more difficult dilemmas I have seen with elder abuse is bruise counting. Almost every patient returned from a hospital to a nursing home has had IVs, lab work and maybe fell once in the hospital. Often this results in a report to social services for the possibility of abuse. We have institutions doing bruise counts and becoming angry at each other and forgetting that we're all here for the patients' benefit and to be alert for actual abuse.

With elder abuse, you have to go more by community standards. Physicians who have been in practice for a while or have known elderly patients through the years can tell if they are aging differently or unexpect-

edly.

Exploitation of elderly people is even more difficult for physicians to spot. One thing we often see in elderly patients is exploitation of their resources. This gets to be a judgment call. Is it exploitation if an elderly patient gives all their money to a family member who uses it to buy drugs? The older person often doesn't want their family who is abusing them to be taken away or arrested. Even if this person treats them badly, their only alternative is a long-term care facility which is unacceptable.

There often are no physical signs of elder abuse, you have to look for differences. You have to notice whether they seem happy, whether they seem to be having an appro-

priate older adulthood.

In older patients I've seen, the abuse has often been wives abusing their husbands. The husband may have abused the wife when they were younger, but now he's frail and the lady has gotten the upper hand. One of

my more recent cases was a man with broken bones, but he suffered from senility and didn't remember being beaten up. His wife, also senile, didn't remember doing it. These cases are difficult because physicians try to leave people home as long as possible — some of them in pretty marginal mental and physical condition — because this is what they want.

For the safety of the elderly patient, you must try to break the cycle of mistreatment the same as you would with a child or a spouse. But, unlike child abuse cases, there is often no loving foster family available for an elderly person. These cases are easier for physicians and patients if we use a team approach rather than try to handle everything ourselves. I've had better luck working with other professionals in a team to investigate and correct the situation. I try to be supportive rather than judgmental.

Finally, it's very important to praise the person who is taking the trouble to care for a dependent adult. Often, they are under a lot of stress and don't get much credit for what they are doing.

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Gun control: Iowa physicians have opposing views

Editors' Note: At this year's IMS House of Delegates, a spirited discussion took place in the meeting of the Reference Committee on Legislation when a resolution was introduced asking the IMS to depart from AMA policy and take a neutral position on gun control. Though the resolution ultimately failed, it was clear this is an issue which sparks much interest. We asked two physicians who spoke at the meeting to answer the following question: Could gun control help stem the rising tide of violence in America?

Guns make efficient killers

Edward Hannon, M.D., radiologist Dubuque, Iowa

AST APRIL DURING THE IMS HOUSE of Delegates meeting, an unusual resolution was introduced which requested "IMS take a neutral position on gun control legislation and that IMS delegates to AMA take a similar position." Neutral. Not for or against. Fortunately, the audience saw that the request was the equivalent of a resolution against gun control legislation. I was one of many who spoke against the resolution. The resolution did not pass and the House of Delegates instead adopted this version: "That the IMS support current AMA policy on gun control."

The AMA supports education on gun safety, a mandatory waiting period for purchase of firearms, restrictions on the sale and ownership of assault weapons and bans on realistic toy guns and firearms that can't be detected by airport screening devices. This certainly seems sensible and conservative but, despite AMA support, legislative attempts at gun control have had minimal effect against the slaughter resulting from indiscriminate and massive use of firearms.

Logically, physicians should want to lessen the carnage caused by pistols and assault weapons. Large urban areas are becoming war zones, and a surfeit of weaponry is

(Continued next page, first column)

More laws won't help

Robert Barry, M.D., dermatologist Cedar Rapids, Iowa

THE QUANTITY AND QUALITY of violence in America is appalling. This epidemic has its roots in the loss of respect for other's lives and property. It is the culmination of society's failure to insist upon individual responsibility for one's acts. It has been abetted by an entertainment media which saturates the minds of our children with an interminable succession of gory killings and maimings where no one ever has to pick up the bodies.

The epidemic of violence has further been exacerbated by a criminal justice system that protects the perpetrator when what is needed is a victim justice system. Judges say that 16 and 17-year-olds are not adult enough to know it is morally wrong to kill, rape, steal or sell drugs. If the defendant exists on a diet of Twinkies, his brain will be impaired sufficiently to preclude his knowledge of the wrongfulness of murder thereby relieving him of accountability.

The above statements notwithstanding, I would no more suggest media censorship or prevention of jury trials than I would allow interference with my constitutionally guaranteed right to keep and bear arms.

There are currently over 20,000 laws controlling gun ownership and transfer. The pas-

(Continued next page, second column)



Edward Hannon, M.D.

available even to children. Most murders in the U.S. are committed with guns, and our murder rate is an embarrassment in comparison to other nations. The lives lost, the trauma generated, the increasing numbers of young patients with spinal cord injuries, post-trauma stress comparable to that in Beruit in the 1980s—there are many reasons to cause all physicians to regret this increasing tendency toward gun use.

A few statistics: In 1985, there were 18.000 murders in the U.S. In 1989, 21.500 Americans were murdered and in 1990 there were 24,440 murders. As I already mentioned, guns are used in most murders; 44% of murders are committed using pistols. According to the National Pediatric Trauma Registry, gunshot wounds among children doubled between 1987 and 1990. Center for Disease Control notes that homicide is the leading cause of death for black males between age 15 and 24 and that 80% of these murders are committed using guns. A young

If this were the Olympics we would retire the prize for the foreseeable future. It is interesting that the CDC in Atlanta keeps these statistics, not just the FBI. This is an epidemic and should garner at least as much medical concern as the morbidity and mortality caused by vehicles and AIDS.

murdered than a white male of the same age.

black male is nine times more likely to be

Unfortunately, this is not thought of as a medical issue. Many other countries, which have also had their revolutions and are voting democracies today, understand that "guns don't kill, people do." But they also understand that "people with guns can kill more efficiently."

This is a political rather than an epidemiologic or public health issue. Those with an

(Continued next page)

Robert Barry, M.D.



sage of more laws is not going to make our society less violent. The enactment of more restrictive legislation on firearms ownership will no more prevent violence (flrearms related or not) than the 18th amendment prevented the use of mind-altering substances. Black market supply, thievery, do-it-yourself inventiveness and alteration or substitution of non-controlled implements will supplant

the prohibited item.

I spent two years doing general medicine in a rural American Indian community in Nevada. Despite free access to firearms of all types, the weapon of choice for serious assaults in that community was a car or truck aimed at the victim. Two locations with virtual total prohibition of civilian firearm ownership (Washington, D.C. and New York City) hardly qualify as safety zones. During the recent Los Angeles riots, armed citizens abandoned by badly outnumbered police—were able to protect themselves from violence while defenseless citizens were killed or maimed. (Yes Virginia, the threat of retribution deters acts of violence.)

I find it incomprehensible that any practicing physician could trust the federal government to do anything right or reasonable after trying to deal with such supposedly necessary and logical measures as RBRVS, OSHA and CLIA. If a staff member drinks a glass of water in the same room where blood or tissue is handled, I am liable for a \$2,000

fine per incident.

At the same time, if a self-proclaimed AIDS sufferer applies to a fast food restaurant to fill the position of food server, the restaurant owner would be subject to civil action if, for that reason, he did not hire that person. Yet, a physician may not perform a microscopic examination of urine or under-

(Continued next page)

Dr. Hannon . . .

absolutist interpretation of the 2nd Amendment succeed in keeping all but the most feeble attempts at gun control from becoming law. NRA and others have prevented effective control of handgun and assault weapons because they deem a literal interpretation as sacred writ. They feel that what was logical two centuries ago in the era of homesteaders fighting bears and Indians must still be logical today. They opposed the few limitations that have been placed on gun sale and manufacture. Restrictions on machine guns and Teflon coated "cop killer" bullets were also opposed by NRA.

To the NRA, there is no difference between the handgun used to murder someone, the homeowner's or shopkeeper's trusty shotgun and the hunter's rifle. The near unrestricted availability of any gun is the NRA interpretation of the Constitution because it has worked so well for over 200 years. Or has it? Things change: there are no more slaves and women vote. Why are we subject to a flood of minimally controlled handguns

and assault weapons?

I do not advocate prohibition of all guns, but strong control on manufacture and sale, particularly of handguns and assault style automatic weapons. Prohibition of alcohol didn't work. We can't control mankind's foolishness or anger with others, but there is no inherent reason we have to live in a land where gunfire is getting to be the norm. The inner cities needn't be like Hue-Phubai during Tet. A nihilistic attitude toward the flood of weapons fostered by an absolute interpretation of the Second Amendment will lead to the ruin of more cities, more lives.

We in mostly safe, mostly rural Iowa need to support our urban colleagues who really live with the problem. Many of us enjoy the challenge and skills of hunting and some of us have used guns against other humans in combat situations. But, if current trends in gun availability and misuse are not reversed, even our quiet towns and small cities will see this problem increase. Iowa had only 62 murders last year, but that was a 15% increase since 1990. The population sure didn't increase that much.

I agree in principle with those who believe "we have enough laws, it's time to jail the offenders." But, it has been my experience that those who strongly support putting

Dr. Barry . . .

take a potassium hydroxide examination of skin scrapings for fungi without paying a federal fee and submitting to inspection (harassment) by a federal agency. What gall. What sheer idiocy we persist in promulgating.

Please notice that the foregoing appeals to logic, reason and pragmatism. I have avoided statistical arguments. Both sides of the gun control argument can present statistics supporting their views. Many of the statistics are suspect. Many of the conclusions drawn as to how to correct the reflected misery are silligisms. Example: Since it is a fact that more than 20% of all police officers killed by firearms in the line of duty are killed with their own weapons, law enforcement officers should be prohibited from possessing firearms.

Further gun control will not significantly alter violence in America. We need to treat the disease—the failure of society to insist upon and enforce responsible behavior—not futilely try to control implements of violence.

more people in jail are usually the least willing to pay the taxes necessary to build more jail space. I believe it would be most cost-effective to control the disease vector (pistol, bullet, rapid fire large ammo clip weapon) at the source (factory, gun-seller). That might prevent an occasional corpse rather than just jailing the murderer after the fact.

No one believes it's simple—drug use is at least as much if not more responsible for the deaths and decline of cities. Not to mention the decrease in the economic middle class, split families and teenage pregnancies. I've seen rough areas of different cities on a few continents, but for a real taste of urban paranoia and a chance for mayhem outside of a war zone, nothing beats what has happened to cities in the good old USA in the past few decades.

It is a shame that misguided fealty to the 2nd Amendment can be measured nowadays by viscera penetrated, families devastated by death, millions of dollars spent on security systems and an intangible decline in trust of strangers and safety of neighborhoods that used to be the norm. Whatever we as physicians and citizens can do to reverse this trend might help a little, but a "neutral" position

surely would not.



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IOWA MEDICINE Interview



Robert McAfee, M.D.

AMA fights back

The vice chairman of the AMA Board of Trustees discusses the AMA's renewed campaign against family violence, including release of protocols for primary care physicians and formation of the Physicians Coalition Against Family Violence.

How does the American Medical Association define family violence?

The AMA recognizes family violence as a public health problem affecting millions of Americans each year. There are many forms of family violence, including child abuse, domestic violence between adult partners and elder abuse.

What are the components of the AMA's Physicians' Campaign Against Family Violence?

The Physicians' Campaign Against Family Violence is designed to help physicians identify and treat victims of family violence.

The AMA has published three sets of diagnostic and treatment guidelines for physicians—on child physical abuse and neglect, child sexual abuse and domestic violence. We plan to release physician guidelines on elder abuse in October.

The AMA is also encouraging physicians across the country to join the National Physicians Coalition Against Family Violence. There is no cost and coalition members receive valuable materials on family violence. We are establishing a National Medical Resource Center on Family Violence to help physicians and other health professionals share information.

A very important part of the national campaign against family violence is the involvement of specialty, state and county medical societies nationwide.

What is the AMA doing to help medical societies get involved in the campaign against family violence?

The AMA is producing a handbook for medical societies titled "What You Can Do About

(Continued next page)

Family Violence." This handbook gives stepby-step advice on how medical societies, auxiliaries, student sections and related groups can work with local family violence service providers. The book also includes several case studies of medical societies' family violence programs, plus a reference section with information on national anti-violence organizations and state coalitions and workshops and seminars.

How many men are battered spouses?

An estimated 5% of domestic violence victims are men. Most of this abuse is probably psychological, involving berating or belittling rather than physical attacks. The AMA Council on Scientific Affairs is planning to look into abuse of men by women.

How much does family violence add to the cost of health care?

Family violence results in 100,000 days of hospitalization, 30,000 emergency room visits and 40,000 trips to the doctor's office each year. In addition to the enormous health care cost, family violence costs American business perhaps as much as \$5 billion annually in lost productivity due to absenteeism.



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Pharmacologic management of aggression and violence

The author discusses the differential diagnosis of violent and aggressive behavior, traditional and alternative treatments and OBRA-90 legislation.

Ted Anfinson, M.D.

Iowa City, Iowa

NEUROPSYCHIATRIC SYNDROMES ARE COMMONLY encountered in chronic care facilities, with up to 94% of residents exhibiting such behavioral phenomena. Furthermore, violence and aggression frequently accompany organic mental syndromes. Violence and aggression secondary to organic mental syndromes represent a significant challenge to the clinician, due largely to the tremendous heterogeneity in underlying organic pathology and their unpredictable response to treatment.

Pharmacologic treatment of aggressive and violent patients is one of the mainstays of management, in addition to comprehensive behavioral and psychosocial treatments. A systematic approach is necessary, however, in the precise characterization of the problematic behavior, development of a differential diagnosis of the cause of such behavior, treatment of any underlying medical condition and in the choice of a treatment plan.

Dr Anfinson is chief resident, Department of Internal Medicine, University of Iowa Hospitals and Clinics.

Identify symptoms

The first step in the management of behavioral disturbances in organic mental disturbances is to determine the precise nature of the problematic behaviors. A patient may be reported to be agitated and the primary caregiver approached with a request to prescribe pharmacologic treatment of the behavior in question. It is incumbent upon the physician to inquire about the specific nature of the behavior, in both qualitative and quantitative terms. A variety of behaviors have been termed "agitation" in patients with organic mental disorders, including verbal aggression, hitting, grabbing, biting, pacing, restlessness, repetitive requests for attention, etc., any of which might be amenable to a variety of treatment modalities. It is equally important to determine the frequency of the behavior and its impact on the ability of the facility to provide care for the patient.2

It is important not to prematurely exclude behavioral and psychosocial treatments for a given problem and to remember that specific indications exist for psychotropic medications; antipsychotic and antianxiety medications should not be seen as all purpose agents for

troublesome behavior.

THE IOWA MEDICAL FOUNDATION HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION AWARD FOR SEPTEMBER 1992

When confronted with a violent patient it is necessary to recognize that the aggressive behavior is frequently a sign of another medical or psychiatric condition. The guiding principle in the treatment of any violent patient is to diagnose and treat any underlying medical or psychiatric condition first, if at all possible. It may be necessary to begin with symptomatic treatment of the aggressive behavior before adequate diagnostic studies can be performed.

'Akathisia is perhaps the most troubling side effect of antipsychotic administration. It is characterized by a subjective sensation of restlessness manifested by increased pacing, rocking, or stereotyped behaviors such as picking or rubbing at one's clothing.'

Conditions associated with aggressive and violent behavior include acute psychosis, mania, organic mental syndromes, delirium dementia, drug intoxication, mental retardation and personality disorders.

Treatment of delirium

Delirium is probably the most important syndrome to consider in the differential diagnosis of aggressive and violent behavior. It is frequently underrecognized and is associated with considerable morbidity and mortality.³ It is a syndrome characterized by disturbances in attention and arousal accompanied by disorganized thinking. The hallmark of delirium is its fluctuating course, which may lead to delays in diagnosis.

The medical conditions associated with delirium are protean and include hypoxia, medication intoxication and withdrawal, metabolic and electrolyte disturbances and central nervous system tumors, trauma and infection. Not all delirious patients require intensive care treatment; most patients can be treated using oral or intramuscular antipsychotics or benzodiazepines in a general medical ward.

Violent and agitated patients in the intensive care unit represent a challenging management problem, however, requiring rapid be-

havioral control to minimize complications such as endotracheal tube or central venous catheter removal, falls, etc. Intravenous sedation is the preferred route of administration, with IV haloperidol and IV lorazepam being the preferred agents.^{4,5}

Advantages to IV haloperidol include minimal respiratory depression, minimal sedation for the degree of behavioral control achieved, minimal alpha adrenergic blockade resulting in less hypotension, and a relative rarity of extrapyramidal side effects when compared to oral administration. If more rapid sedation is required, intravenous lorazepam may be added to the haloperidol regimen, with the caveat that greater attention must be given to potential respiratory and hypotensive effects when combinations are used. Once adequate sedation has been achieved, a less aggressive dosage strategy can usually be employed.

Medications to be avoided in the routine management of delirious ICU patients include narcotics and neuromuscular blocking agents.

Traditional treatments

Antipsychotics and benzodiazepines are probably the most frequently prescribed agents used in the control of behavioral disturbances secondary to organic mental conditions. The use of antipsychotic agents in dementia has been summarized in several recent reviews.^{67,8} Response rates varied from 30-60%, with noisy, irritable, abusive, destructive and combative behaviors responding best to treatment. Elderly patients with apathy, withdrawal, incontinence and severe disorientation responded less well to treatment and had a high incidence of sedative and pseudoparkinson side effects.⁹

The choice of an antipsychotic agent is dictated by its side effect profile. In elderly patients, it is usually prudent to use a high potency agent such as haloperidol or trifluoperazine. These agents have comparatively less propensity for sedative, anticholinergic and orthostatic effects, although a greater likelihood of extrapyramidal effects. Similarly, it is usually prudent to start with a low dose (1-2 mg haloperidol) and to titrate to clinical response. Intramuscular administration of haloperidol should be accompanied by a 50% reduction in dose. Some clinicians have advocated the use of intramuscular or intravenous droperidol, citing its shorter half life as a theoretical advantage, but there are few data evaluating this alternative neuroleptic. 10

TABLE 1 SIDE EFFECTS OF ANTIPSYCHOTIC DRUGS

Sedation Anticholinergic side effects Orthostatic hypotension Extrapyramidal side effects Acute dystonia Pseudoparkinsonism Akathisia Tardive dyskinesia

Neuroleptic malignant syndrome

TABLE 2 BEHAVIORS THAT SHOULD NOT BE AN INDICATION FOR ANTIPSYCHOTIC USE

Wandering

Poor self-care Restlessness Impaired memory Anxiety Depression Insomnia Unsociability Indifference to surroundings Fidgeting Nervousness Uncooperative attitude Unspecified agitation

Side effects of antipsychotic medications are listed in Table 1. Acute dystonic reactions can be treated with 50 mg IV diphenhydramine or 1 mg IM benztropine. Pseudoparkinsonism can be treated with anticholinergic agents or amantadine. Akathisia is perhaps the most troubling side effect of antipsychotic administration, because it is often difficult to distinguish from the primary behavioral disturbance. It is characterized by a subjective sensation of restlessness manifested by increased pacing, rocking, or stereotyped behaviors such as picking or rubbing at one's clothing. Treatments of akathisia include low dose beta blockade, anticholinergic agents, or benzodiazepines.¹¹

Benzodiazepines are frequently prescribed for treatment of nonspecific agitated or anxious behavior. Studies evaluating the efficacy of benzodiazepines in geriatric patients with a variety of psychiatric disturbances (primarily dementia) have revealed response rates of 24%-87%. ¹²⁻¹⁶ Significant side effects of benzodiazepine therapy include somnolence, tolerance, and withdrawal upon abrupt discontinuation.

Alternative treatments

While benzodiazepines and antipsychotic medications are often sufficient to reduce violent or aggressive behavior in patients with organic brain syndromes, it is not uncommon to encounter patients in whom these treatments are either ineffective or accompanied by intolerable side effects. A number of alternative pharmacologic strategies have been evaluated in these settings including beta blockers, lithium, carbamazepine, and trazodone.

Beta blockers have been used in a number of settings for treatment of organically disturbed behavior. Most reports involve small case series, and only two prospective placebo-controlled double blind crossover trials exist, both in dementia patients. ^{17,18} Response rates of 77%-82% have been noted in patients with dementia, 75% in autistic patients, 100% in acute brain damage, and 84% in

retarded patients.17-22

Several studies have evaluated lithium in the behavioral control of mentally retarded patients.²³⁻²⁷ Response rates vary from 50% to 73%, with serum lithium levels ranging from 0.5 mEq/l to 1.4 mEq/l. Results from the largest double-blind placebo controlled trial (N = 42) suggested that a six to eight week trial was necessary to determine benefit, while 36% of patients developed significant side effects.²³

Side effects of lithium therapy include polyuria, polydipsia, tremor, loose stools, and alterations in thyroid function. Baseline renal and thyroid function tests should be performed before starting lithium therapy and serum levels should be closely followed. Lithium should be used with caution in combination with diuretics, which reduce lithium clearance.

Carbamazepine has been evaluated in the behavioral management of patients with dementia, and mental retardation. Response rates were 33% and 49% in the studies evaluating mentally retarded patients and 100% (7/7) in the study involving dementia patients.²⁸⁻³⁰ Mentally retarded patients in whom hyperactivity is the predominant symptom may respond better to carbamazepine than those with a wider repertoire of behavioral disturbances.

Trazodone has been noted to decrease organically disturbed behavior in 4 patients with a variety of neuropsychiatric syndromes, including dementia, Korsakoff's syndrome, and ethanol abuse complicated by brain injury.³¹

Behaviors that are not an indication for antipsychotic use are listed in Table 2.

(Continued next page)

Prescribing under OBRA-90

In October, 1990, a number of regulations concerning sweeping reforms in nursing home care were enacted under the Omnibus Budget Reconciliation Act (OBRA).³² The Health Care Financing Administration has subsequently provided interpretive regulations of these laws.³³ Other authors have reviewed these guidelines in more detail.³⁴⁻³⁸ While these guidelines may appear cumbersome and intrusive to some, the intent of the legislation has been to help ensure that patients in chronic

'Conditions associated with aggressive and violent behavior include acute psychosis, mania, organic mental syndromes, delirium dementia, drug intoxication, mental retardation and personality disorders.'

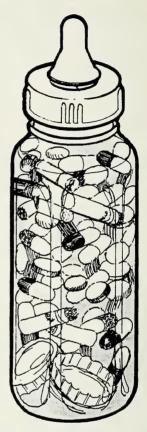
care facilities receive pharmacologically sound treatment of behavioral disturbances.

No 'unnecessary' drugs

The next portion of the legislation deals specifically with the use of antipsychotic drugs, stating that antipsychotic drugs should not be given unless they are necessary to treat a specific condition, and those patients receiving antipsychotic drugs receive gradual dose reductions, drug holidays, behavioral manipulations, unless clinically contraindicated, in an effort to discontinue the medications.

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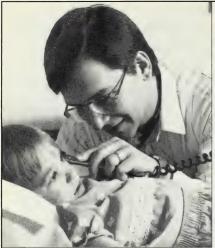
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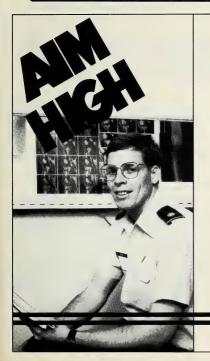
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Thoughts on spelling and writing

Richard M. Caplan, M.D.

SHORTLY AFTER my last column, a note came from a friend of many years, Dr. William Catalona of Muscatine, who complimented me (it seemed) on my using words that sometimes sent him to his dictionary. I say "seemed" not because my effort to communicate misfired, but because he cared enough to want to understand me. Maybe he just wanted to catch me making an error. He surely succeeded.

I had referred to "carnoptic" jars used by the ancient Egyptians, into which certain viscera were taken from the corpse, placed in jars decorated with corresponding representations of deities (jackal, falcon, etc.) and entombed with the mummy. Bill wrote that he couldn't find "carnoptic" in his dictionary. Naturally, that sent me to mine, then to the Oxford English Dictionary, then to a reference librarian who was likewise unsuccessful. Puzzled and irked at all those deficient dictionaries, I called for help at the University's Museum of Art, where one of the curatorial staff was able to locate the missing word: canopic. I wrote Bill that my memory is even more fallible than it used to be. Although spelling may come more easily to some than to others (suggesting a structural or genetic/ neurologic base), there can be no serious question that practice can produce improvement—children who win the national spelling bee practice a lot and the results show.

To some extent, my wife's dictum about spelling holds true: to find a word in the dictionary, you must already know how to spell it, or be pretty close. Her favorite example, drawn from the days when she worked as a transcriber of medical dictation, was her great frustration/failure at finding the word "erythema." She knows full well, however, that it was not her "humorous" but her "hu-

merus" that she recently fractured and mended. It should be much easier to be a fine speller in Spanish or German, for example, where the rules of spelling conform rigidly to pronunciation. That suggests, though, that everyone speaking Spanish speaks "pure" Castilian—certainly not so. I wonder if "spelling bees" can have any meaningful existence in countries that have fixed rules of orthography that derive from sound. Surely in this country, George Bernard Shaw's campaign for sensible phonetic spelling (in which "yf" spells "wife") has a long crusade ahead of it. We may even implement the metric system sooner than that.

According to the exceedingly popular stereotype, physicians have terrible penmanship, even those who grew up when legibility was a valued skill, dutifully practiced in schools. At that same time, the corresponding drills in spelling seemed to produce good spellers, thus marking the well-educated person. Poor legibility, however, never seemed to impugn one's intelligence or moral status. More recently, childhood education has devoted less attention to either skill, and it seems that doctors, like others, give evidence of the deficiency.

Many explanations have been advanced to explain the frequently poor legibility of physicians. Frankly, I'm not sure their penmanship is indeed worse than that of an age and education-matched group, such as Supreme Court judges or non-medical university professors, or whether such a study has ever been attempted. But even if I grant that physicians as a group are champions of poor legibility, I believe it can be largely attributed to the great circumstance of haste that usually characterizes doctors at work. Slowing down and thinking about producing more legible text can really produce improvements, if not win prizes. That's certainly so in my case.

Writing is ordinarily a handmaiden to thinking. We are trained to attend mainly to content. When we wish, we can likewise at-

Dr. Caplan is Coordinator, Program in Medical Humanities at the University of Iowa College of Medicine.

tend to such otherwise automatic processes, once learned, as walking, swimming, speaking, etc. But if a choice must be made, then generating content, solving problems, and expressing effectively the results of thinking must take precedence over the more mechanical process of penmanship. Or even spelling. The ultimate effect of computers on either function will be interesting to behold. Recall that Socrates opposed writing because he thought it would obliterate the operation of memory.

Congratulations Dr. Caplan

Dr. Richard Caplan is the recipient of this year's Hancher-Finkbine Medallion, one of the highest honors bestowed by the University of Iowa.

Dr. Caplan, who was associate dean for continuing medical education for many years at the U. of I. College of Medicine, received the award in recognition of his achievements in and contributions to leadership, loyalty and learning. He was cited for the distinction of excelling in medical science and the humanities.



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A vital link for physicians, staff

IN A MODERN MEDICAL PRACTICE THERE MUST be an emphasis on communication and teamwork among staff members. There is no right or wrong way to accomplish this goal. What works for one clinic may not work for another, but the effort put forth and the process itself are important. All staff — physicians through receptionists — need to strive toward efficient and effective accomplish-

'In today's medical environment of constant change, access to the most current information gives employees the capacity to respond appropriately to patient inquiries. It is important that employees come together as a team and talk.'

ment of the work. The better communication has developed, the more fully we can concentrate on our primary objective — taking care of patients.

Patients look to us to take care of them and all clinic personnel must work together to serve their needs.

Each staff component of a practice (doctors, nurses, laboratory technicians, insurance coordinators, accounts receivable bookkeepers, receptionists) must work with the others to meet the objectives of the clinic. In today's medical environment of constant change, access to the most current information gives employees the capacity to respond appropriately

to patient inquiries. It is important that employees come together as a team and talk.

Communication strategies

- Schedule meetings once a month over the lunch hour and expect all staff to be present. Eat together and discuss areas of concern such as upcoming insurance changes, scheduling changes and other vital information. Encourage each staff person to express his or her thoughts and share recommendations and ideas.
- Schedule individual department meetings as the need arises to discuss issues which can be solved within the department.
- Place a notebook in the employee lounge. Put all clinic memos in it which have been circulated and read by all employees.
 This book should be available to any employee at any time.
- Place a large clinic calendar in the employee lounge where all upcoming vacations/days off can be recorded in addition to employees who work on Saturdays.
- Provide written clinic policies in a booklet to each employee.
- Furnish a bulletin board in the staff lounge displaying OSHA posters, credit union flyers, IRS bulletins and other important information.

Use an erasable message board in the lounge — list meetings and write notes to employees, especially birthdays and other celebrations.

Send written memos to the physicians whenever possible. This is an effective way of communicating without interrupting patient flow. Ask the doctors to read the memos when they have time, to consider the content, write comments on the same sheet and return to the office manager.

Author Laura Olberding is office manager of the Doran Clinic in Ames.

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*The recommended starting dose for Calan SR is 180 mg once daily. Dose titration will be required in some patients to daily. Does drawn will be required in some patients of a achieve blood pressure control. A lower initial starting dosage of 120 mg/day may be warranted in some patients (eg., the elderly, patients of small stature). Dosages above 240 mg daily should be administered in divided doses. Calan SR should be administered with food.

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#Verapamil should be administered cautiously to patients with impaired renal function

BRIEF SUMMARY
Contraindications: Severe LV dysfunction (see Warnings), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (sp. WW or LCL syndromes), hyperensitivity to verapamil.
Warnings: Verapamil should be avoided in patients with severe LV dysfunction (e.g. ejection fraction < 30%) or moderate to severe symptoms of certains failure and in patients with any degree of vertricular dysfunction (e.g. election fraction < 30%) or moderate to severe symptoms of certains failure and in patients with any degree of vertricular dysfunction if they are receiving a beta-blocker. Control milder heart failure elemenstrated to be produced by verapamil. Produce monitoring of liver function in patients on verapamil is prudent. Some patients with proxymal and/or chronic atrial flutter/fibrillation and an accessory Apthway (e.g. WPW or LG. syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid extinction response or vertricular in the patients. AV block may occur (2nd- and 3rd-edgree), 0.3%). Development of marked 1st-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arest, pulmonary elemen and/or severe hypotenson were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil

with verapami. Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular viscophy and may prolong recovery from the neuromuscular brokening and recurrence with the property of the necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergio blockers and verapamil any result in additive negative effects on heart rate, attioventricular conduction and/or cardiac contractility, there have been reports of excessive bradycarda and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metapproli and propriatelol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of attended. Chronic verapamil tratement can increase serum digorius levels by 50% to 75% during the first veek of therapy, which can result in digitals toxicity. In patients with happaic crithosis, verapamil may reduce total body cleanance and extrarental clearance of digitation. The digital colors should be reduced when verypamil is given, not the patients receiving blood-pressure-lowering agents.

Disopyramide should not be given within 48 hours before or 24 hours after verapamil administra-tion. Concomitant use of flecalmide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolaration. Combined verapamil and quintifine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in an increased densitivity to lithium (neurotoxicity), with either no change or an increase in serum lithium levels; however, it may also result in a lowering of serum lithium levels. Patients receiving both drugs must be monitored result in a lowering of serum inhium levels. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifiampin may reduce verapamil bioavailability. Phenobartital may increase severapamil clearance. Verapamil may increase serum levels of cyclosprin. Verapamil may inhibit the clearance and increase the plasma levels of theophyline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful straint to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a caranogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumoriganic potential, and verapamil was not mutagenic in the Ames test. Pergnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milit; therefore, nursing should be discontinued during needed.

verapami use.

Advense Reactions: Constipation (7.3%), dizziness (3.3%), nauses (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), futigue (1.7%), dyspena (1.4%), bradycardair. HR < 50/min (1.4%), AV block: total 1.72; 3" (1.2%), 2" and 3" (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudicion, mycoradio infraction, appliations, purpure incessuriiis, synoppo, Gairnea, dry mouth, gastrointestinal distress, gingiyal hyperplasia, ecchymosis or brusing, cerebrovascular accident, contasson, equilibrium disorders, insomia, muscle cramps, parsentess, psychotic symptoms, shakness, somnolence, arthralgia and rash, exanthema, flat loss, hyperteriatosis, maculess, waveling, uricans, Severen-Johnson yndrome, erythema, flati loss, hyperteriatosis, maculess, waveling, uricans, Severen-Johnson yndrome, erythema, flati loss, hyperteriatosis, maculess, aveland, uricans, Severen-Johnson yndrome, erythema, flati loss, hyperteriatosis, maculess, aveland, uricans, Severen-Johnson yndrome, erythema platine, burner vision, synecomastius, glactorrhea/hyperprolistinema, increased unination, sporty menstruation, impleator.

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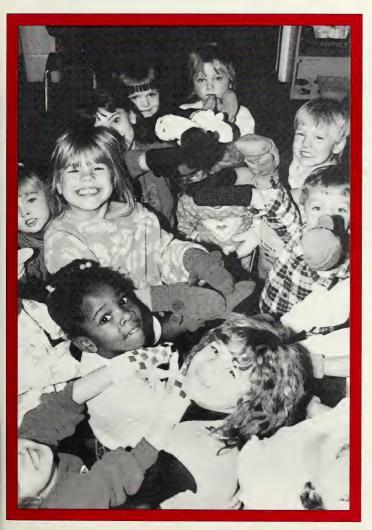


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October 1992

Journal of the Iowa Medical Society

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- Iowa children should have their immunizations by age two, the latest guidelines say, page 400.
- When physicians recommend breast cancer screening, patients tend to listen, *page 407*.

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This month's guest photographer is Todd Behrends, communications specialist for Central Life Assurance Company, Des Moines. This photo was taken at the Naomi Wright Day Care Center in Des Moines.

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Since 1985 there has been an 18% increase in the

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Douglas Hornick, M.D., Larry Schlesinger, M.D., Richard Wenzel, M.D.

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President's Privilege



William Eversmann, Jr., M.D.

What sort of health care reform?

WE SHOULD LEARN from education. Not just our own education but the education system. A few years ago someone noted, "Johnny can't read." Everyone got excited. Curriculum was changed. "Reform" occured. Johnny still can't read.

Medicine has already viewed for 25 years the methods and results of government controlled health care from the perspective of the Medicare system. I cannot help but speculate that if it were not for the cost shifting to cover the Medicare deficit and the charity of hospitals and physicians, the entire Medicare system would have failed long ago.

Physicians cannot, therefore, allow this type of "reform" to again befall the delivery of health care. We must simply oppose health care reform that doesn't benefit the patients and improve the delivery of health care to the public. Unfortunately, some reforms that have been proposed are similar to past reforms in education. What they propose for medicine is about the **control** of health care rather than the **delivery** of health care.

Accordingly, the medical profession must support health care reform that effectively supports patient care rather than reform as some politicians advocate from the "top down." Let us be sure that the reforms of health care delivery focus on the patient, the public and the delivery of health care rather than on administration, controls, rule making and bureaucracy.

To structure health care reform from the bottom up rather than the top down, the public—our patients—must be empowered to control their health care. This can only occur in a meaningful way if we educate them on the complexities and intricacies of the health care delivery system. We have that responsibility to educate and communicate with our patients and the public about the importance of directing health care reform to the patient's needs, thereby reforming the health care delivery system from the bottom up. If we do not assume this responsibility, others with less experience in the health care system will be happy to do it for us.

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The Editor Comments



Marion E. Alberts, M.D.

An ongoing challenge

Would it not be better business to spend more money to prevent the incidence of illness rather than to spend many times that amount to cure it? — Henry E. Sigerist (1891-1957)

PREVENTION, WHETHER IT BE of illness and disability or strife and conflict, is an attribute which seems unacceptable to a large portion of our society. Certainly prevention is a concept extolled many times over in our modern society. Yet, we wonder; is everybody listening?

This issue of IOWA MEDICINE examines two major concerns: immunization for control of several diseases more prevalent in childhood and the increasing incidence of tuberculosis. Prevention programs could eradicate tuberculosis and the childhood diseases for which immunization measures are available. Proof? Worldwide vaccination programs to prevent small pox have been successful. No worldwide smallpox outbreaks have been reported in recent years and since 1949 there have been no cases in the United States.

Measles was on the decline, but in recent years there has been some increase in incidence, mainly due to laxity in prevention or untimely reimmunization. In some areas of the world there has been an increase in the numbers of children affected with pertussis; again due to laxity in preventive measures. The prevention of tetanus has been very suc-

cessful in the U.S. military because of mandatory immunization, with no cases reported during several wars.

New vaccines and modifications of existing vaccines have been a part of my years in practice. The victories over poliomyelitis, measles, mumps and rubella, diphtheria, tetanus and pertussis and more recently hepatitis are milestones in the prevention of disease. But we cannot become lax in our vigilance; the concern for prevention must be rigid and ongoing.

Likewise, we must be concerned with problems of resistance developing in the treatment of several diseases, notably tuberculosis. New strains of the causative organism defy traditional drug therapy. Prevention of tuberculosis remains high on the public health agenda but treatment is also a concern.

The havoc wrought by the myriad of microorganism is a concern of all. We in the health profession must be leaders by educating our patients as well as promoting active programs of prevention. The public must accept major responsibility in availing themselves of preventive measures. The government must promote and enact public health programs. Disease due to microorganisms can be conquered; and then we can address new vistas in the promotion of good health through preventive means.

Pediatric immunizations in Iowa

lowa's children need to complete their immunizations by the time they are two years old, according to new standards issued by the National Vaccine Advisory Council.

Charles Danielson, M.D.

Des Moines, Iowa

A LARGE NUMBER OF OUR children are not immunized, a fact which was graphically illustrated by the surge in measles cases that occurred in 1989 and 1990. In this outbreak, the cases occurred largely among unimmunized patients, causing the largest number of measles-related deaths in almost two decades.

Despite improvement in the number of measles cases during the current calendar year, the vulnerability of preschool children to vaccine-preventable illness remains. The health objectives for the nation, contained in the Healthy People 2000 Plan and the Healthy Iowans 2000 Plan, call for a minimum of 90% of children to have recommended immunizations by their second birthday.

Iowa's immunization rates for preschool children are similar to national rates. A recent study showed at age two, only 52% of Iowa children had been adequately immunized with DPT, polio, and the measles, mumps and rubella vaccine. This is in sharp contrast to the immunization rate for Iowa's school age children which is 97%. It is generated

ally accepted that Iowa children are not being completely immunized as soon as they should be.

In an effort to improve immunization practice, the National Vaccine Advisory Committee published *Standards for Pediatric Immunization Practice* in May of 1992 (See Table 1).

The standards clarify factors which limit the provision of immunizations. While cost is generally accepted as a barrier to immunization, there are many others. The Advisory Committee's standards can be helpful in reducing these additional barriers and will aid in lowering the age when immunizations are completed.

One overriding theme of the standards is taking advantage of every immunization opportunity, or any interaction of a child with the health care system when an immunization would be medically appropriate.

Access to immunization

Six standards (1-4, 8 and 10) are predominantly concerned with immunization access. The concept of readily available immunizations includes a wide range of hours when services are available and one-stop shopping, which means including immunization as an important component of primary care by private providers. The standards call for screening children's immunization status at all clinical encounters and for immunizing at all appropriate contact times.

Dr. Danielson is medical director, Division of Family and Community Health, Iowa Department of Public Health.

TABLE 1

STANDARDS FOR PEDIATRIC IMMUNIZATION PRACTICES

- 1. Immunization services are readily available.
- There are no barriers or unnecessary prerequisites to the receipt of vaccines.
- Immunization services are available free or for a minimal fee.
- Providers utilize all clinical encounters to screen and, when indicated, immunize children.
- 5. Providers **educate** parents and guardians about immunization in general terms.
- Providers question parents or guardians about containdications and, before immunizing a child, inform them in specific terms about the risks and benefits of the immunizations their child is to receive.
- Providers follow only true contraindications.
- Providers administer simultaneously all vaccine doses for which a child is eligible at the time of each visit.
- 9. Providers use accurate and complete recording procedures.
- Providers co-schedule immunization appointments in conjunction with appointments for other child health services.
- Providers report adverse events following immunization promptly, accurately and completely.
- 12. Providers operate a tracking system.
- Providers adhere to appropriate procedures for vaccine management.
- Providers conduct semi-annual audits to assess immunization coverage levels and to review immunization records in the patient populations they serve.
- Providers maintain up-to-date, easily retrievable medical protocols at all locations where vaccines are administered.
- Providers operate with patient-oriented and communitybased approaches.
- 17. Vaccines are administered by properly trained individuals.
- Providers receive ongoing education and training on current immunization recommendations.

The standards also call for free or minimal cost vaccines. The National Vaccine Advisory Council believes immunizations should be free in the public sector and available for the cost of the vaccine plus a "reasonable administration fee" in the private sector. Most primary care physicians would provide vaccines if cost and reimbursement were not concerns.

The "no barriers or unnecessary prerequisites" policy (Standard 2) is very broad. The National Vaccine Advisory Committee statement calls for minimal office/clinic waiting periods and for offering immunizations without requiring other comprehensive patient services.

Other well child care should be provided, but these services should not impede timely immunization. In the public sector, says the Committee, "the administration of vaccines should not be dependent on individ-

ual written orders or on a referral from a primary care provider. Rather, standing orders should be developed and implemented."

Not requiring a comprehensive exam before vaccine administration can be a problem for overall care when children receive only immunizations. However, it can also help bring about access to families who have not used the system.

If a previously "unserved" family begins to establish a relationship with a provider who meets immunization needs promptly, the family may schedule an appointment for comprehensive care. Previously, such an approach evoked concerns by providers regarding patient liability. The developed national standards should actually reduce potential liability in such situations.

Education

Standards 5, 6, 7 and 18 deal with vaccine contraindications. Immunization practice requires a knowledge of true contraindications, the need for ongoing education and administration by well-trained individuals. Traditionally, professional organizations have played a major role in these issues.

The recent introduction of vaccine information pamphlets has renewed discussion on how much information from parents or guardians is enough. The federal requirements that physicians must use these pamphlets could seriously undermine efforts to improve immunization coverage. Presently, alternatives are unavailable if a provider wishes coverage under the federal vaccine compensation program.

Practice management

Standards 9, 11, 13 and 15 address several practice management activities. Vaccine management requires maintenance of the cold chain and observation of expiration dates. Recording of an immunization should include the type of vaccine, date, manufacturer, signature of the administerer and title and address where the vaccine was given.

A personal immunization card should be filled out including what vaccine was given plus the date and name of the provider to assure the parent has a complete record.

Medical protocols should address injection sites, techniques, adverse events and emergency management of complications.

(Continued next page)

Guidelines could be developed and distributed by professional organizations to their members. Any adverse events should be reported to the Vaccine Adverse Event Reporting System (VAERS), 515/281-4917.

Tracking systems

Standards 12, 14 and 16 specifically address assuring that all children receive needed vaccines. Tracking systems can be simple cardbased tickler files or sophisticated automated systems. Children in need may be tracked by

telephone, mail or home visits.

Immunization audits (reviews of patient records to determine whether patients are staying on schedule for immunizations) are a valuable tool for identifying needs and a potential area for quality improvement sponsored by professional organizations. Though there will be community variation in how systems work, coordination of care to children could be improved by public-sector outreach to private providers and strengthened communication among providers. If immunizations are provided with comprehensive care, use of outreach can strengthen other preventive services as well.

Missed opportunities

A major missed opportunity is non-simultaneous administration of vaccines. It is unfortunate that more antigen combinations are not given to reduce the number of needed shots. Besides increasing compliance, simultaneous administration of vaccines would also increase the number of visits without any shots, thus allowing for more painless interactions with the child.

The immunization program in Virginia estimates that simultaneous administration of vaccine during the second year of life can increase two-year-old immunization rates by over 20%.

Another barrier to proper immunizations is false contraindications resulting from misinterpretation of indications for withholding a vaccine. There are many misunderstandings on when to give vaccines and when not to. For example, minor illnesses such as upper respiratory infections with or without a low grade fever, are not a valid reason to withhold immunizations nor is concurrent antibiotic treatment.

In some situations, immunizations might be withheld if symptoms associated with com-

'A recent study showed at age two, only 52% of Iowa children had been adequately immunized. This is in sharp contrast to the immunization rate for Iowa's school age children which is 97%.

mon vaccine reactions could result in delayed treatment of an undifferentiated illness, but these are exceptions. Clinical judgment, as always, remains important.

Immunizing children during visits for other family members or at appointments made for other types of care poses a challenge to busy practices, but not immunizing children in these settings results in missed vaccine opportunities.

Contraindications table

A table of true and false contraindications is available by calling the Iowa Department of Public Health at 515/281-4917.



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Medicaid Vaccine Replacement Program

TOWA IS PARTICIPATING in a Medicaid vaccine replacement program sponsored by the U.S. Department of Health and Human Services that allows the state to purchase vaccines at a lowered cost using federal contracts. Beginning August 1, a new state program—the Physician Medicaid Vaccine Replacement Program—developed by the Iowa Department of Public Health (IDPH) and the Iowa Department of Human Services (IDHS) took effect for the following vaccines:

Code	Description
90701	DTP
90702	DT, pediatric use
90707	MMR, live virus
90712	OPV
90718	Td, for adult use
90731	Hepatitis B Recombinant Vaccine by
	Merck, Sharp, and Dohme
90737	HIB (Hibtiter by Lederle)

Medicaid began separately reimbursing the injection administration fee as of July 1, 1992, instead of including the injection in the price of the drug. Medicaid will accept CPT injection codes 90782, 90783 and 90784. The above-listed vaccinations require use of a modifier indicating the doses within the series. Claims for these vaccines without the numerical modifier will be denied.

Modifier	Description
01	First dose
02	Second dose
03	Third dose
04	Fourth or more dose

The acellular DTP vaccine, however, will continue to be reimbursed. It should be coded as a 90749, unlisted immunization, with the drug name and price listed in blocks 24D and 24F respectively on the claim form.

This article was written by Christopher Atchison, Director, Iowa Department of Public Health.

A vaccine replacement vial will initially be sent to participating physicians upon completion of processing a claim that reflects one of the immunization codes. Since vaccine vials typically contain multiple doses, Medicaid will monitor use of that vial through paid claims; another vial will be sent when paid claims indicate there are five or fewer doses left in the vial. An exception is for Hepatitis B which is replaced on a one for one basis. A monthly vaccine utilization report will show the status of replacement vaccines.

There are two exceptions to the immunization replacement program: 1) Medicaid recipients enrolled in an HMO having a contract with the IDHS for specific Medicaid services (currently, this is available only in the Davenport area); and 2) Medicaid recipients who are also eligible for Medicare when the vaccine is covered by Medicare. In these cases, the current reimbursement process will remain the same. Vaccines not listed, such as the acellular DTP vaccine, will also follow current reimbursement procedures.

Here are common questions and answers on the program.

Do I have to keep my vaccine for Medicaid recipients separate from my vaccine for other patients?

No. Practical office management calls for finishing a multidose vial of vaccine before opening another, regardless of the recipient's pay source. Most vaccines are interchangeable with two exceptions: The *Haemophilus influenzae* vaccine and the Hepatitis B vaccine. In these cases, a child should receive the same manufacturer's vaccine to complete a primary series. In this limited situation, a provider could choose to maintain an inventory of several brands of similar vaccine.

How do I bill for vaccine replacement?

The provider needs to bill the appropriate CPT vaccine code as well as the injection administration CPT code, 90782. Medi-

(Continued next page)

caid will replace the vaccine when a CPT code reflecting a vaccine covered in the immunization replacement program is used. Medicaid will make payment for the injection administration fee when CPT 90782 is used.

Are modifiers to the immunization CPT codes necessary?

Yes. The IDPH is required to report immunization use to the Centers for Disease Control. As a result, the physician needs to reflect the dose in the series. If the physician is providing the second dose in a series, the modifier 02 must be recorded. For all immunization replacement vaccines, modifers must be used, including for Td (for adult use). Claims without a modifier will be denied!

What about use of vaccine from various manufacturers? Won't that be a problem? What manufacturers will be supplying the vaccines?

The following vaccines/manufacturers will be used for the Physician Medicaid Vaccine Replacement Program.

٠	Vaccine	Manufacturer	
	DTP	Connaught	
	DT	Lederle	
	Td	Lederle	
	OPV	Lederle	
	HIB	Lederle-Praxis	
	MMR	Merck, Sharp, and Dohme	
	Hepatitis B	Merck, Sharp, and Dohme	

What about acellular DTP? Is is subject to the immunization replacement program?

No. When acellular DTP is utilized, CPT 90749 should be used. A description of the vaccine administered must be described for reimbursement. Medicaid may later add acellular DTP to the program after conducting a study of the cost effectiveness of including it and after assignment of a CPT code.

Participation in this Medicaid program is estimated to save the state of Iowa \$1 million. It is part of a comprehensive state plan, called Iowa's Infant Immunization Initiative, to ensure that 90% of children in Iowa are completely immunized by their second birthday. Currently, about 50% of Iowa children under 24 months are fully immunized.

An immunization awareness program is being conducted, including posters, pamphlets, and inserts in Aid to Families with Dependent Children (AFDC) checks.

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IOWA MEDICINE Interview



Dean Gesme, Jr., M.D.

Heightened breast cancer awareness among lowa women

October has been designated as Breast Cancer Awareness Month. The author, a Cedar Rapids oncologist and new president of the lowa Division of the American Cancer Society, discusses the important role physicians play in breast cancer detection among lowa women.

A woman's chance of developing breast cancer has now been lowered from 1 in 10 to 1 in 9. Does this mean more women are developing breast cancer?

The incidence of breast cancer is increasing worldwide. This is true not only in the United States but in both industrialized and developing countries of the world. The cause for this is more than lead time bias or improved reporting of the disease. Environmental and dietary factors are suspected but epidemiologic studies to date have not been conclusive.

Are more lowa women having mammograms and, if so, is it affecting the breast cancer picture for lowa women?

The availability and utilization of screening mammography is now well developed

throughout the state of Iowa. Therefore, each year sees an increase in the number of Iowa women having mammography. Certification programs for mammography sites which are being implemented in Iowa should minimize patient and physician concerns regarding safety issues and maintain quality control.

How important is it for physicians to discuss screening mammography with their patients?

The women's movement has heightened the awareness of both patients and physicians regarding breast cancer issues. None the less, polls have shown that the majority of women still rely on the recommendation of their physician in regards to screening mammography.

The responsibility is clearly with primary care physicians to motivate and inform

(Continued next page)

women about mammography. The importance of this cannot be over emphasized. Mammography is an excellent opportunity for physicians to be seen as "providers of health" rather than "mechanics of disease."

According to a recent Iowa Department of Public Health article, a "substantial minority of physicians are not following consensus recommendations on breast and cervical screening. What is the reason for this?"

It is important for physicians and their office staff to provide reassurances to women that these procedures need not be embarrassing,

painful or threatening.

Busy physicians often are overwhelmed with patients demands for treatment to the point that preventive health care is overlooked. The lack of third party payment by many health insurers—despite the demonstrated cost effectiveness of screening mammography and cervical screening—is a major detriment to implementation for women meeting screening guidelines.

Fortunately, many womens' groups in Iowa are raising funds to provide screening mammography to low income women. Physician support will demonstrate the commitment of Iowa's medical community to im-

prove health care accessibility.

October has been designated as Breast Cancer Awareness Month. Do you plan to focus on breast cancer during your term as President of the Iowa Division of the American Cancer Society?

The American Cancer Society (ACS) will continue to emphasize the importance of screening mammography as well as supporting education and research regarding other breast

cancer issues.

The ACS has sponsored considerable research into possible prevention strategies regarding breast cancer. The National Cancer Institute has begun the Breast Cancer Prevention Trial (BCPT) which utilizes Tamoxifen or placebo in a double blind randomized trial to see if this might prevent breast cancer in high risk female populations. This is now available to women in a number of Iowa communities.

It is interesting to note that as the women's movement has fostered awareness of breast cancer there is growing interest by the ACS and the public regarding prostate

cancer.



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Resurgence of Tuberculosis

Since 1985 there has been an 18% increase in the number of cases of tuberculosis nationally. Even more alarming is the increasing incidence of multidrug-resistant tuberculosis which presents a serious public health problem, particularly for HIV-infected patients.

Douglas Hornick, M.D. Larry Schlesinger, M.D. Richard Wenzel, M.D.

Iowa City, Iowa

Nationally, we are seeing alarming increases in tuberculosis (TB), particularly antibiotic resistant strains. This problem is closely related to the AIDS epidemic. Over 26,200 cases of tuberculosis were reported in 1991, with the largest increase in the 25-44 year old age group.¹

At least two thirds of the cases occur in minority groups such as Hispanics, native Americans, blacks and Asians. HIV infection has played a major role in the re-emergence of TB, and although the major risk behavior for HIV infection in those with TB and HIV was initially IV drug abuse, increasingly all HIV risk behaviors are being represented.¹

Among the HIV-infected population, TB does not fit into the classic mold. Diagnosis requires a high index of suspicion and demonstration of the acid fast bacilli (AFB) in tissue. One cannot completely rely on sputum sam-

ples, the PPD skin test (5 TU purified protein derivation or Mantoux skin test) or demonstration of granulomas histologically. Because of the frequency of extrapulmonary involvement, search for active disease should be undertaken in selected patients as indicated by the clinical findings (i.e., lymph node biopsy, bronchoscopic lavage and/or biopsies, pleural fluid, urine examination, liver biopsy, bone marrow biopsy, cerebrospinal fluid examination and ascitic fluid examination). If active TB or acid fast bacilli are not detected, any HIV patient with a positive PPD should receive isoniazid (INH) for one year regardless of their age, since coexistence of HIV infection and TB carries such a strong risk for development of active disease (8-10% per year). Also, since INH preventive therapy is felt to remain effective in this patient population, every HIV-infected patient should be skin tested. These patients generally respond well to preventive therapy despite coinfection with HIV.

Multidrug-resistant tuberculosis

Multidrug-resistant tuberculosis (MDRTB) organisms are resistant to at least INH and rifampin (RIF). The breadth of MDRTB is not yet fully appreciated. The likely source for these organisms is patients in whom therapy was

The authors are associated with the University of Iowa College of Medicine.

THE IMS EDUCATION FUND HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION AWARD FOR OCTOBER 1992

incomplete. ^{1,2} A nationwide CDC report showed that the resistance rate in the U.S. is increasing. From 1982 to 1986 only 0.5% of *M. tuberculosis* isolates from newly diagnosed cases were INH and RIF resistant. By 1991, however, multidrug resistance among isolates from new cases had risen to 3.1%. In the case of TB recurrence after prior treatment, the resistant rates increased even more alarmingly in early 1991 to 6.9%. Eleven states have reported INH and RIF resistant strains and the highest rates of resistance are localized to large metropolitan centers, particularly New York City. ¹

Currently available therapeutic regimens are less effective for treating MDRTB. The mortality range for active disease with MDRTB is 72 to 89% in HIV patients.¹ These high rates suggest an interaction between HIV infection and multiple drug-resistant strains and illustrate the reality that there are no proven therapeutic regimens for treament of active MDRTB disease. Furthermore, there are no proven alternatives to INH for prevention of progression to active disease among those infected with MDRTB.

TB in Iowa

In Iowa, the TB case rate is 2.6/100,000, still low compared to the national rate of 11/100,000. However, the annual number of new TB infections reached its nadir in 1986 at 44 and has since increased. In 1991 there were 71 new cases. The percentage of cases in the 25-44 year age group is slowly rising. Racial and ethnic minorities accounted for nearly one third of the cases in Iowa in 1991. The Asian immigrant population accounted for 12 cases last year with a case rate of 47/100,000, substantially higher than the overall rate of 2.6 for Iowa.⁵

Drug resistant TB has been identified in at least seven cases in the last 18 months, and four have been resistant to two or more drugs. The majority of the drug resistant cases have occurred in foreign born individuals, and have all been effectively contained.⁵

Progress toward detection

Both the State Hygienic Laboratory and the University of Iowa clinical laboratory are utilizing a new system that can detect mycobacterial growth in four to seven days after inoculation. Speciation of clinically relevant organisms can be made at that point utilizing specific DNA probes for *M. tuberculosis, M. avium-intracellu-*

lare, and M. gordonae (common contaminant). When M. tuberculosis is identified, the same early growth detection method can be used to determine drug susceptibility to Isoniazid, Rifampin, Streptomycin and Ethambutol in approximately one additional week.

Nosocomial transmission

Recently there have been a number of reports of the nosocomial spread of MDRTB among hospitalized patients with AIDS.^{3,4} Exposure to patients with tuberculosis on the same ward was a risk factor, and the closer their hospital room to the index case the more likely that patients acquired the infection via airborne spread. Medical personnel have been infected as well. In some New York hospitals, the one-year PPD skin test conversion rate was recently 22-55% among health care workers.⁴

There is an urgent need to prepare a safe hospital environment for the care of TB patients. The requirements for containment of TB, particularly MDRTB, in the hospital are:

 Hospitals must provide patient and procedure rooms (i.e., bronchoscopy) with negative air pressure relative to the hallway and with non-recirculated air.

 Hospitals should provide an education program for personnel that stresses the mode of TB transmission, the need to identify TB patients as early as possible and the need for prompt isolation of both probable and definite cases.

 Hospital microbiology laboratories should attempt to utilize newer, more rapid techniques to identify the bacterium.

 The institution's annual PPD skin test program should be re-evaluated.

Recommendations

Specific asymptomatic high-risk populations should be routinely screened using the 5 TU PPD skin test (Table 1). In persons in whom active disease is suspected, a chest x-ray, sputum smear and culture should also be performed.

Recent epidemiologic data have resulted in new criteria for interpreting the PPD skin test result. For any household contact of an infectious case, any patients with fibrotic lesion on chest x-ray that is consistent with previous TB, or any HIV seropositive individual, 5 mm of induration is considered positive. For non-HIV, at risk populations for TB (i.e., populations recommended for screening), 10 mm of

TABLE 1

INDIVIDUALS FOR WHOM TB SCREENING IS RECOMMENDED*

- 1. Household contacts of persons known or suspected to have TB
- 2. Persons with conditions known to increase risk of disease
 - HIV infection
 - · HIV seronegative intravenous drug abusers
 - rapid weight loss of > 10% of ideal body weight or chronic poor nutrition (i.e., malabsorption syndromes, carcinoma of upper GI or oropharyngeal region, chronic alcoholism, or jejunoilial bypass)
 - · postgastrectomy without weight loss
 - · chronic renal failure
 - diabetes mellitus
 - patients on prolonged corticosteroid or other immunosuppressive therapy
 - previously untreated patients with scars on chest x-ray consistent with prior TB
 - hematologic malignancies (leukemia, lymphoma)
 - silicosis
- Persons from foreign countries with high incidence of TB (Latin America, SE Asia, Pacific Islands, and Africa)
- Medically underserved, low income persons, and high-risk ethnic minorities (blacks, Hispanics, and native Americans)
- 5. Residents of chronic care facilities and correctional institutions
- 6. Health and child care workers

induration is considered positive. For low-risk populations, 15 mm of induration is considered positive.⁶

The lifetime risk of progression to active disease after infection (positive PPD) is approximately 10% for normal individuals. INH is highly effective in reducing the progression to disease. INH (10 mg/kg daily for children, up to a maximum adult dose of 300 mg daily) for six to 12 months should be administered to individuals at high risk (Table 2). The full 12 months of INH is recommended for HIV-infected and other immunosuppressed patients; nine months of INH is recommended for children; and six months is recommended for all others.⁷

Treatment of active TB

Current recommendations from the CDC and the American Thoracic Society (ATS) have placed emphasis on knowing the drug susceptibility of the organism in planning therapy. In treating most adults and particularly patients from certain patient populations (i.e., SE Asians and Latin American migrant workers in Iowa), the recommendation is to initiate therapy that includes coverage for drug resistant strains. The initial regimen includes four drugs pend-

TABLE 2

INDICATIONS FOR TUBERCULOSIS PROPHYLAXIS IN PATIENTS WITH A POSITIVE PPD*

- Known HIV infection or patients in high risk group for HIV infection, but HIV status is unknown (PPD ≥ 5mm)
- 2. HIV seronegative intravenous drug abuser (PPD ≥ 10 mm)
- 3. Household contacts
- 4. Recent (less than 2 years) PPD skin test conversion (≥ 10 mm for those ≤ 35 yrs. ≥ 15 mm for those ≥ 35)
- Patients with medical conditions that increase their risk for TB (PPD ≥ 10 mm)
- Those not in above risk categories, PPD ≥ 10 mm, and ≤ 35 y.o. who are:
 - foreign born in high prevalence area (Latin America, Asia, Pacific Islands, Africa)
 - medically underserved, low income, high risk ethnic/racial group (black. Hispanic, native American)
 - · long-term care facility resident
 - staff members of correctional institutions, chronic care facilities, hospitals, child care centers, schools

ing drug susceptibility tests. The duration of therapy is at least six months and should be continued at least three months beyond sputum conversion to AFB negative. Specifically, the CDC and ATS recommend INH (adults: 5mg/kg or a maximum of 300 mg) and Rifampin (adults: 10 mg/kg or maximum of 600 mg) daily for all six months, supplemented by Pyrazinamide (adults: 15-30 mg/kg or maximum of 2.0 gm/day) during the first two months of therapy, and Ethambutol (15-25 mg/kg or amaximum of 2.5 gm/day) or Streptomycin (15 mg/kg or a maximum of 1 gm/day) until drug susceptibility results are available.^{7,8}

Where TB is suspected (nonimmunosuppressed patient), but the sputum smear and the culture are negative, the six-month regimen may be reduced to four months. This regimen is also recommended for patients with a positive PPD and concurrent silicosis or chest x-ray evidence of previous TB. These patients were previously recommended to receive INH prophylaxis only.⁷

In cases of HIV co-infection or serious extra-pulmonary TB infection (i.e., meningitis, miliary TB), it is recommended that INH and Rifampin be continued for at least nine months and at least six months beyond sputum conversion, because of the low therapeutic margin of safety in these patients.⁷⁸ In the case of active disease with MDRTB, there is no proven effective regimen. It is recommended that the regimen be individualized based on the drug sus-

(Continued next page)

^{*}Based on information in reference 6.

^{*}Based on information in reference 6.

ceptibility data and that it contain at least three drugs to which the organism is susceptible. Two drugs should be continued at least 12 months beyond sputum conversion, which usually results in 18-24 months of therapy. 17 Because the cure rate is less than 60%, surgical debulking of the organism load should also be given consideration if the disease is localized. 9 Alternative drugs such as the quinolones (i.e., ciprofloxacin, ofloxacin), rifamycin derivatives (i.e., rifabutin), newer macrolides (clarithromycin, azithromycin), clofazimine, and betalactam/beta-lactamase inhibitor combinations (i.e., amoxicillin/clavulanate) have shown promise against MDRTB. 1

Directly observed therapy is strongly advised in all situations where poor compliance is suspected or proven. Directly observed therapy has been shown to be effective when administered intermittently either two or three times weekly in patients without drug resistant TB.^{7,8} Twice weekly therapy can begin after two weeks of daily therapy with INH, Rifampin, Pyrazinamide, and Ethambutol or Streptomycin. All four drugs are continued for six weeks twice weekly, then INH and Rifampin alone for the subsequent 16 weeks (Table 3). Three times weekly therapy has no daily therapy component, INH, RIF, Pyrazinamide, and Ethambutol or Streptomycin are given three times weekly for six months.

In cases of drug resistant TB or in patients in whom sputum conversion does not occur within the first two to three months of therapy, consultation with a TB medical expert is recommended.

Conclusion

Complacency and disregard for the potential problems caused by the rapid resurgence of TB elsewhere in this country pose a real threat to Iowa. We must raise the awareness of the potential problems posed by the resurgence of TB. Efforts should be focused on:

- Education for primary care physicians and other health care workers.
- Surveillance for drug resistant strains of TB.
- Development of effective plans for TB surveillance and containment in hospitals, correctional facilities, and chronic care facilities with provisions for MDRTB.
- Continued improvement in laboratory identification of TB and drug susceptibility testing.

TABLE 3

DOSAGES FOR INTERMITTENT TREATMENT OF TUBERCULOSIS IN ADULTS*

Drugs	Twice weekly (mg/kg)	Three times weekly (mg/kg)
INH	15 (max. 900 mg)**	15 (max. 900 mg)
RIF	10 (max. 600 mg)	10 (max. 600 mg)
Pyrazinamide	50-70 (max. 4 gm)	50-70 (max. 2.5 gm)
Ethambutol	50 (max. 2.5 gm)	25-30 (max. 2.5 gm)
Streptomycin	25-30 (max. 1.5 gm)	25-30 (max. 1.0 gm)

*Based on information in references 7, 8.

**For example, a 70 kg man would receive on Mondays and Thursdays: 900 mg INH, 600 mg Rifampin, 4 gm Pyrazinamide, 2.5 gm Ethambutol, and 1.5 gm Streptomycin.

- Adequate public health services to deal with this problem.
- HIV testing of all individuals with TB or significant exposure to TB because of the increased severity of disease in this population.

References

References are available from the authors or the editors of *IOWA MEDICINE*.





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New name for Iowa Medical Foundation

THE IOWA MEDICAL FOUNDATION, a component of the IMS which supports educational and scientific activities for physicians and the public, will now be called the IMS Education Fund. The name change was approved at the Foundation's annual meeting in March.

During its nearly 40 years of existence, the IMS Education Fund has been the source of loans for 743 medical students. These loans total \$2.2 million. The Fund represents the largest source of nongovernmental funding for medical students at the University of Iowa.

During the most recent academic year, the IMS Education Fund provided \$178,220 in loans to 43 students.

The IMS Education Fund also includes the Dr. Henry Albert Physician Benevolence

and Public Health Fund. The Fund has received over \$316,000 from this source since the mid-1960s. This money is available to help needy physicians and their widows and support programs such as the IMS Assistance Program for Troubled Physicians, the Hawkey Science Fair and other projects.

The main source of funding for all these activities is Iowa's practicing physicians. Over the past 15 years, the IMS Education Fund has received average contributions of over \$420,000. In 1991, 424 physicians contributed \$21,200 to the IMS Education Fund.

LETTERS TO THE EDITOR

If you have a comment regarding something you've read in *IOWA MEDICINE* or an observation on conditions affecting the practice of medicine in Iowa, don't keep it to yourself. Share your thoughts in a letter to the editor. We'd like to hear from you.



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Nominations and applications will be accepted until the position is filled. The Committee is particularly interested in Identifying minority and women candidates. Applications should include a curriculum vitae and the names, addresses, and telephone numbers of five references. Please send nominations or applications to:

Richard D. Williams, M.D., Professor and Head, Department of Urology Chair, Search Committee for the Dean of the College of Medicine 126 CMAB, The University of Iowa Iowa City, Iowa 52242

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Patient evaluation: timeliness matters

A FTER NURSING HOME STAFF WERE unable to obtain a blood pressure reading, a 75-year-old male with a history of COPD was admitted to the intensive care unit midday, April 7. The primary diagnosis was hypotension with a secondary diagnosis of dyspnea. Upon admission, his blood pressure was 108/80 in his left arm and 70/00 in his right. His temperature was 98.2°F at noon and 99°F at 8 P.M.

He was dyspneic at rest and had been on continuous oxygen therapy prior to admission. The attending physician ordered, via the telephone, a complete blood count, a urinalysis, a chemistry profile and arterial blood gases. Later that evening, ABG results indicated a pH of 7.30, a PO2 of 66, a PCO2 of 57 and an O2 saturation of 90% on three liters of oxygen. April 7 nursing notes documented the patient's respirations were rapid and shallow. A chest x-ray performed that same day indicated the patient had a large right pleural effusion.

According to the transfer information from the nursing home and the H&P, the patient wished to have maximum resuscitation measures.

An hour and 20 minutes after admitting the patient, the attending physician gave a telephone order to transfer the patient to the medical floor, where the patient died the next morning.

Reviewer comments

This patient was not evaluated adequately. Although there were two progress notes dated April 7 and signed by the attending physician, neither one was timed. The second note indicated the patient was alert and stable and could be transferred to a medical

bed. However, nursing staff noted on the admission form that the patient was unable to answer questions about person, place and time.

There was also an untimed progress note written by the physician dated April 8. Two orders were dated the same day: one was a telephone order to stop code and chest compressions timed at 8:30 A.M.; the other order, "release to mortuary," was not timed.

There were no entries by the nursing staff regarding the physician's evaluation of the patient. Because of this and the fact that only telephone orders were documented, there was concern that the patient was neither seen nor evaluated by the physician prior to his death.

The patient had only been in the ICU for an hour and 20 minutes when the physician transferred him to the medical floor. Neither the stability of the patient's condition nor the results of the tests were known at the time of transfer.

It was documented by the attending physician and the nursing staff that the patient wished to have maximum aggressive care. Because of this, the physician should have evaluated the patient in a timely manner. In addition, because the patient was hypotensive and his level of consciousness was unstable, the physician should have promptly evaluated the abnormal chest findings. The physician documented in the discharge summary that the patient died before a thoracentesis could be performed; however, a thoracentesis should have been considered the day or evening of admission.

Failing to appropriately evaluate the patient placed the patient at risk of death due to respiratory or cardiac failure or another unrecognized condition. This case was assigned a severity level III: confirmed quality problem with significant adverse effect(s) on the patient.

This article was written by Dr. Louis Banitt, an Ames internist and IFMC reviewer.

The why of accreditation

Richard Nelson, M.D.

THE RECENT REPORT OF THE Robert Wood Johnson Foundation's Commission on Medical Education states, "Tomorrow's physician will be required to have a broader range of working knowledge about many things, from molecules to management, and to know how to continue to learn despite pressures to the contrary."

Continued learning can occur in almost unlimited form, but true to the American character we typically organize ourselves to learn. How many practicing physicians choose to accompany a colleague on hospital rounds to gain another perspective on patient care? Probably few, although such a format can provide an excellent learning experience. Instead we structure lectures, produce audiotapes and develop courses targeted to specific physician audiences. We organize!

The current plethora of continuing medical education activities presents a jumble of opportunity to the physician interested in learning. In a perfect world, persons with knowledge and skills helpful to this learner would present programs and materials in a consistently pertinent and objective fashion. Teaching would be effective and innocent.

Unfortunately, the world is neither perfect nor are our teachers always innocent. Experts may lack expertise relevant to the learner's needs; teachers may also lack objectivity due to over reliance on their personal experi-

ence or allegiance to products and equipment provided by commercial supporters.

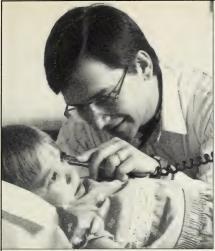
It is in this milieu that the accreditation of continuing medical education has developed, not only as a type of "consumer protection," but also to stimulate high quality continuing education offerings.

The formal body accrediting continuing medical education is the Accreditation Council for Continuing Medical Education, a collaborative group of seven national medical and health care organizations. This Council is best known in the CME world as the entity that accredits sponsors of CME activities to designate those activities for Category 1 credit.

Yet the Council has a broader role. The Council accredits institutions and organizations "to sponsor continuing medical education for physicians." Such accreditation is not an automatic process. Within recent months the Office of Continuing Medical Education at the College of Medicine participated in the reaccreditation process. Extensive materials were collected to document our adherence to seven "essentials" in the provision of CME.

Iowa physicians should be relieved to know that we passed this review and will not be resurveyed until 1996. In the interim we will be responding to a number of recommendations made by the Council to our program. Those recommendations include strengthening the educational objectives of programs, further assessment of the quality of the instructional process and expansion of evaluation efforts. We now more fully appreciate the "why" of accreditation!

Dr. Nelson is associate dean for continuing medical education at the University of Iowa College of Medicine.









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Autonomous patients

Robert Weir, Ph.D.

NE OF THE ETHICAL PRINCIPLES of medicine is a respect for autonomy which calls for physicians and other parties to a case to abide by the free and rational choices of a patient whenever the choices are (1) consistent with the patient's value system and (2) will not bring significant harm to one or more other persons.

However, questions commonly arise in clinical cases regarding patients who may or may not have the capacity to be autonomous. Which patients have the capacity to make decisions regarding their own health care? Does a 15-year-old female patient have the capacity to make decisions about contraception or abortion, including decisions with which her parents may not agree? Does an 85-year-old patient have the capacity to refuse medical or surgical interventions, including medical treatments and/or surgical procedures her physician thinks will be beneficial? Does any patient have the capacity to refuse recommended treatment, even when the treatment is life-sustaining in nature and the patient's family disagrees with the patient's decision?

Until a few years ago, such questions were framed in the psychiatric and legal language of "competency." Now, however, there is an increasing recognition that references to "competent" and "incompetent" patients are problematic for several reasons. First, the language of competence and incompetence is best understood as legal terminology used to describe individuals whose mental status has been the subject of a formal legal hearing. Very few hospital patients are therefore incompetent.

Second, the concept of competence is task-specific: one is competent to do something (e.g., manage personal finances) under

specified conditions. By contrast, the concept of autonomy pertains to one's self-governance in various aspects of life.

Third, competence is an all-or-nothing concept, whereas autonomy is a flexible concept that more closely fits medical reality. Some patients are clearly autonomous, others are clearly nonautonomous and some are best described as having diminished or fluctuating extraorems.

ating autonomy.

The concept of autonomy has three cognitive and decisional components. To be an autonomous agent requires that one have the capacity for (1) understanding (able to grasp basic pieces of information, comprehend consequences of certain actions, etc.), (2) deliberation (perceive options, consider alternatives, make choices), and (3) voluntariness (decide and act in the absence of internal and external constraints that limit or control one's decisions and actions).

All autonomous persons, whether patients or not, have these general capacities of understanding, deliberation and voluntariness in decision and action. However, the capacities differ in degree from one person to another. Some persons have reduced autonomy that significantly affects their ability to make decisions about health care and other important matters.

Three additional, more specific decision-making capacities are involved in decisions to accept or refuse life-sustaining treatment: (4) *authenicity* (the decision reflects patient's value system), (5) *communication* (the patient can communicate verbally, or through eye blinks, hand squeezes, electronic devices, etc.) and (6) *appreciation* (the patient is aware of personal significance of decision).

Patients who possess these capacities are autonomous and should, with very few exceptions, have their decisions respected and carried out. Decision making with patients who lack these capacities will be discussed in a fu-

ture column.

Dr. Weir is director of the program in biomedical ethics for the University of Iowa College of Medicine.

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INSIDE THIS ISSUE . . .

The tragic story of a physician in crisis, page 440. . Where do opiate addicts get drugs? You may be surprised, page 445.

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Volume 82 Number 11

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November 1992

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The diversity of IMS members and IMS-affiliated organizations is demonstrated by this photo, taken in front of the lowa Medical Society's West Des Moines headquarters.

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Feature Article

440 In a heartbeat

He was a promising 28-year-old resident physician with a bright future. Then, he was found dead of a selfadministered drug overdose. In an interview reprinted from The Colorado Physician Health Program Newsletter, his widow discusses his death and what it means.

David Reiser, M.D.

Scientific Article

455 Opiate Addiction in Iowa

lowa physicians are sometimes tricked by people supporting a drug habit.

Daniel Murphy, M.D.

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President's Privilege



William Eversmann, Jr., M.D.

Pledge of Allegiance

NE HUNDRED YEARS AGO for the celebration of the 400th anniversary of the discovery of America by Christopher Columbus, Francis Bellamy, a Baptist minister, wrote a pledge which was published in a magazine entitled, *The Youth's Companion* which read, "I pledge allegiance to my flag and the republic for which it stands—one nation indivisible—with liberty and justice for all." This pledge was included in the official 1892 Columbus Day commemorative program of the national public school celebration of the discovery of America by Columbus.

In 1923 at the First National Flag Conference, the words "the flag of the United States" were substituted for Mr. Bellamy's designation "my flag" to ensure that the foreign born would not think of the flag of their native land when reciting the pledge.

The next year at the Second National Flag Conference the words "of America" were added so the pledge now read, "I pledge allegiance to the flag of the United States of America and to the Republic for which it stands—one nation indivisible—with liberty and justice for all."

In 1942 Congress formally recognized the pledge by incorporating it into a law as Section 7 of the official flag code of the United States. In 1945—again by act of Congress—Bellamy's oath was officially named the "Pledge of Allegiance."

Not until 1954, when at the request of President Dwight D. Eisenhower, Congress added the words "under God" between nation and indivisible, did the pledge take the form with which we are familiar today, reading, "I pledge allegiance to the flag of the United States of America and to the Republic for which it stands—one nation, under God, indivisible—with liberty and justice for all."

Organized medicine progresses and improves as has the Pledge of Allegiance to the flag of this country. Each of us working diligently, thoughtfully and with the blessing of whatever God we worship contributes something, be it ever so small, to medicine and to the health care of this country. I encourage every physician to join us at the Iowa Medical Society and the American Medical Association and to contribute to the profession.

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The Editor Comments



Marion E. Alberts, M.D.

Count your blessings

As we approach the final weeks of the year we can reflect upon the events of the past months. Americans are unique in celebrating a special day of thanksgiving. It is appropriate that Thanksgiving Day precedes Christmas by a month. The expressions of thanks proceed to the spirit of cheer and good will. Then, in another week we face a new year with renewed expectations. What a wonderful procession of attitudinal objectives we experience during the last two months of each year.

Óur world and our country have experienced devastating disasters this year...man made disasters of conflict in war-torn countries resulting in millions of homeless and starving people. More recently disaster uncontrollable by humankind struck Florida, Louisiana and Hawaii. Most of us never have experienced the horrors of war and mob rule, nor the devastation of floods, tornados or hurricanes. For that we can be thankful.

"When upon life's billows you are tempest tossed; When you are discouraged, thinking all is lost; Count your blessings, name them one by one." So begins an old traditional hymn that carries the message of Thanksgiving. Those of us who are healthy, have a warm comfortable home, a loving family and the financial ability to procure the luxuries as well as the necessities of life truly do have many blessings.

Yet among our peers we hear grumbling about receiving too little for our professional skills. We hear dissatisfaction with various edicts about how to practice medicine. Many complain that peer review is an intrusion into the practice of medicine. Others complain of restrictions on their hospital privileges. The forgotten entity herein is the great amount of freedom we do have compared to people of other parts of the world.

Not only do we have considerable freedom in our professional lives, but in our civic and social existence. Jeane Kirkpatrick stated in a speech that "The reason so many people around the world yearn for America is that they see something here which we Americans often lose sight of — because it surrounds us and pervades our society. What they see, that we miss, is our freedom."

I have come full circle from being thankful for escaping the ravages of war and hunger and devastation of natural disasters to the freedom that we have. We feel frustrated by restrictions; yet reflection upon our personal and professional life reveals freedoms not present in other parts of the world.

As Thanksgiving Day draws near . . . no, everyday — count your blessings one by one. They are numerous; they are unique to those of us in America. Then in December express love and goodwill and cheer as we look with hope and greater expectations to a new year.

In a heartbeat

Beth Sims, widow of a 28-year-old Colorado physician who died of a drug overdose, says addictive disease doesn't have to be fatal. This interview with Mrs. Sims is reprinted with permission from The Colorado Physician Health Program Newsletter.

David Reiser, M.D.

Denver, Colorado

N JULY 3, 1991, DR. RICK SIMS, a second-year resident in anesthesiology at the University of Colorado Health Sciences Center, was found dead in a call-room in University Hospital. The cause of death was an overdose of Sufenta, a potent intravenous narcotic, which he had self-administered. In the ensuing days, the event quickly became a media circus, with sensational accounts of his addiction and death saturating the newspapers and local TV news channels. What these accounts failed to address was the human dimension of the tragedy. Dr. Sims was a physician of intellect, charm, and great promise. He was 28 when he died. He left behind a wife, Beth, also 28, and two young daughters, Jennie, age 2 and Betty, four months. He left parents who grieve deeply for him. And he left his teachers and peers at the University of Colorado in a state of bewilderment, grief and shock. Everyone involved felt a gnawing sense of helplessness and guilt. How could his addictive illness have advanced so far without detection? Why had no one intervened? Once again, a young physician of promise was dead from the twin diseases of

alcoholism and drug addiction. It was not the first time, and it will not be the last.

In the months since her husband's death, Beth Sims has spoken on several occasions to groups of medical students, house officers and physician spouses. Her message is straightforward: tragedies such as Rick's are not inevitable. Addictive disease, while a serious problem, does not have to turn into a deadly one. A person suffering from addiction no longer has to face an inevitable downward spiral of hopelessness, loss, public disgrace and the end of a medical career. Help is available, and people do recover. Beth makes the point, moreover, that no professional license is worth a human life.

In order to recover, however, afflicted physicians and their families must first come out of the shadows and accept help. This is something that virtually every addicted physician resists stubbornly. To resist help is in the very nature of the disease. Recovery almost always begins with detection and confrontation by family, colleagues, and friends. When such a confrontation can not be effected (and it is seldom accomplished easily), addictive disease will invariably progress and get worse.

With these realities in mind, Beth agreed to meet with the Colorado Physician Health Program (CPHP) for an interview. We initially wondered if we should publish the interview under a pseudonym. But in the end,

Dr. Reiser is the editor of *The Colorado Physician Health Program Newsletter*, Denver, Colorado.

with Beth's agreement, we decided to use real names. So much notoriety, innuendo, and media insensitivity had already surrounded her husband's death that we all decided it would be more helpful, and healing, to publish the interview without disguise.

We met Beth at her place of employment. She has a striking presence—a petite, dark-haired woman with luminous, cobalt-blue eyes, quick, decisive gestures, and a firm no nonsense handshake. She approached the interview with friendliness and just a hint of formality, but her grief and pain quickly became apparent.

CPHP: Why don't you begin wherever you feel it is appropriate?

Beth: They found Rick in a call-room at University Hospital on July 3 and . . . he was dead. He had overdosed on Sufenta. He had had a problem for a while. I'd caught him. He'd come home eight or nine days before, late, and told me that he had a problem. Like

'Anybody who has an addiction, or contemplates suicide, should have to go visit a funeral home and pick out a casket for someone they love. It's an incredibly cruel thing to do to somebody.'

all addicts, he said he could handle it and it wasn't a big deal. He thought he could lick the problem if I'd support him. I thought about asking him to leave the house. But I didn't. Even now, I'm not sure I would have done it any differently.

I had found a needle in the bathroom under a throw-rug nine months before that. That time it was morphine. I had caught him one other time, using Versed. There were a number of other times that I suspected it, but couldn't prove it. And of course like all addicts, he lied.

We do know, in retrospect, that quite some time before all this, he'd been at a CPHP meeting. It wasn't a confrontation directed at him. It was one of those orientation sessions for residents that they do. Rick was there. Several people from CPHP remember him. But, somehow, when we had our last

major confrontation, eight or nine days before his death, CPHP never came up.

CPHP: Which is one of the problems with this illness. The disease fights to survive at all costs. When, looking back on it, do you think Rick's problem began?

Beth: Maybe college. Maybe even high school. I never saw anyone who could drink as much as he could and still appear to be so-

'He just couldn't hang on to the reality of where the addiction was actually taking him.'

ber. It would be nothing for him to have three or four huge eight ounce tumblers of Jack Daniels and coke over ice on a given evening. He was doing that even back in college. Almost every night. It never seemed to affect him. One time he said to me, "I'm not an alcoholic because I only like Jack Daniels and if they don't have that, I don't drink at all." And, for many years, that was true.

I first recall really being troubled by his drinking when he was in his third year of medical school. I went with a friend to a self-help group at that point. Actually, I started going because I was working with a woman whose husband had a definite problem, and she wanted me to bolster her resolve, so she wouldn't have to go to the meetings alone. I said, "Sure, I don't have any problem with going to those meetings. Rick is always studying, or out playing poker with his friends, anyway."

From the outset, Rick hated my going there. Because, you know, it was obvious what effect all this had on me. Even though I had gone not consciously thinking that I was there because Rick had a problem, I would go and all these women would be sitting around, talking about how to better themselves and the kind of positions they were in because of their alcoholic spouse, and it was easy for me to begin to decide, "Well, maybe Rick is an alcoholic, after all." He drank too much. Too often. Way too much. And it never appeared to affect him at all. How can you drink that much and not get drunk? Unless you have a problem. What I learned at the group began to open my eyes.

(Continued next page)

Ultimately, I quit going after several months. It was a summer thing. I had had the time and told myself in the fall that I had gotten too busy. But I had also begun to sense that it was causing me more problems in some ways than it was solving. It was rocking the boat, to say the least. It certainly threatened Rick. So, I quit going and a short

'There are more important things than losing your medical license. Like, losing your life.'

time later I got pregnant with our older daughter, Jennie. To be honest with you, I started to feel like a hypocrite. Here I was, getting pregnant. If I really was acknowledging that this man was an alcoholic, then why was I going out and getting pregnant? The truth is, for why I quit going, is that, in the end, it was just easier. . . .

CPHP: It sounds like you and Rick both said a silent prayer that, maybe, if you just hoped hard enough, the problem would somehow recede and go away, and you could go on with the life you had planned for yourselves. Beth: That's right. That's exactly right. You just hope that it will all go away. . . . So, that's what we did and nine months later, we had a baby. It happened real fast, too. I was pregnant within a month of starting to try.

You know, I think part of the problem was, for so long Rick was so lucky. He was lucky and charming. I remember, he was pulled over for a DUI about three months before he died. He was 1/100th of a point under the legal limit. . . . So, they let him sit there for several hours until he was legal and then let him go. No ticket. No reprimand. If it had been me, I'd have been ticketed. Maybe put in jail! But Rick seemed to be charmed. He'd always squeak out of trouble.

CPHP: Do you sometimes wonder, if Rick hadn't been such a Golden Boy, if he hadn't been so graced, and charming...

Beth: That he might still be alive? All the time! Or if I'd pushed the point more. I feel guilty. His parents feel guilty. We all let him squeak by. He was the luckiest person. He was truly charming. And he always got away with it—always. Until he didn't get away

with it, and it was too late. You can't help wondering what the implications were, of your letting him get away with it, so many times, even though at the time you thought you were doing it because of his career, because this time he was really going to try. You thought you were doing it out of love. And, in a way, you were. Doing it out of love.

And now, I've got a daughter who is just like him. It's really spooky sometimes. She has exactly the same traits he had.

CPHP: And you're worried that...

Beth: Positively! I mean, what am I going to tell these kids about their father? At some point they have to know. Fortunately, she's only three. I don't have to tell her for a while. But, yeah, she scares me. She works me, and charms me, just like he did.

But getting back to Rick: I was about three months pregnant with our younger daughter, Betty, when I caught him with the needle the first time. He was near the end of his internship. It was morphine. I remember wondering, "Why would an intern have morphine?"

I was in the powder room and I remember that I told myself I was just neatening things up. So, I moved a throw-rug and found it. But I think I'd gone in there looking. He wasn't acting right that evening, weaving, slurring his speech a little.... Oh, I remember! He'd come down to the laundry room that evening, unusually cheerful. I was folding clothes and he asked if he could help. I didn't even think he knew where the laundry room was! This was most definitely not normal. "Uh uh," I said to myself. "What's wrong?" He was standing there smiling, weaving. So, I discovered the needle that night and confronted him.

"What's this doing in the bathroom?" I said.

And he lied to me.

I remember, I was incensed. Incensed, and hurt and angry. And I remember—he was scared. I threatened to kick him out that night. To leave him. And I was serious. I was going to tell his parents. I was going to tell the whole world. And now, I think, if only I had. If only I'd followed through on that threat, I wonder what might have happened. Would it have turned out differently?

And he told me, he promised me—and this would be the only promise he would

ever break in the 12 years I knew him—he promised me that if he ever did it again, he would move out.

The second time I caught him, I said, "That's it! You are out of here! I don't want your stuff here. I am not raising my children in this kind of environment! Pack your bags and get out!"

But he pleaded.

"No," he said. "I want to stay. We can work this out. I want to do something about this. Together. I know we can handle it if we just stick together."

How do you ignore that? When this is the person you love? This is the father of your children. And you so desperately want to believe that it's true.

So, he promised, once more. And that was the last time I caught him. It was eight days before he died.

'If I'd known about it, and if I'd really believed that it was anonymous, and was really safe, I would definitely have called (CPHP).'

I remember, we talked that night about Narcotics Anonymous. He was going to solve this problem. We would do whatever it took.

But I also recall something else from that night. Something very disturbing. I had found another needle. It was a real small gauge needle. And I had called him at the hospital and confronted him.

"You'd better get your story straight," I said. "Because I think you've been lying to

I remember that he said he'd be right home, and it ended up being an hour and a half. He said he'd just been driving around. But you know—this is terrible, but I think he needed the time to shoot more drugs before he was emotionally prepared to face me that night.

He came home, anyway, that much later, and said, "Beth, I think I've got a serious problem."

For the first time he said he was willing to do anything. He was willing to go to counseling. He was willing to go to Narcotics Anonymous. He knew he had a really serious problem and he was finally ready to confront it.

He was full of sincerity and contrition that night.... But the next morning, it was a whole different story. The denial, the defensiveness all came back.

To be honest with you, up to the very end I don't think I had any idea of how really serious this situation had become. I kept hoping that, if I just didn't look, it would somehow all go away.

CPHP: It's very possible that he was feeling the same emotions himself. If he just shot up one last time, and gave himself a few more precious hours of psychological peace, then, in the morning, he'd find the strength and resolve to lick the problem, for once and for all. **Beth:** That morning, anyway, after all the promises of the night before, he started to back-peddle. I remember he was really concerned about losing his career. I mean—that was a big deal! He didn't want to teach high school chemistry or work in a lab. He couldn't imagine any life, other than being a doctor. And so on and so forth. And in truth, he'd always wanted to be a doctor. Since he was a kid. He never ever wanted anything else. So, in the end, I relented on my threats. One last time. And then, a week later, he was dead.

CPHP: Were you surprised by his death?

Beth: Yes and no. It wasn't completely unexpected. When his Chairman phoned me, he asked me if he could come over and talk with me, that something had happened to Rick. I knew it must have something to do with drugs. I didn't know if he'd been caught stealing them, or if he was dead. I admit, the thought did cross my mind. But, no, deep down I wasn't surprised.

CPHP: How has it been for you since Rick's death?

Beth: There are good days and bad days. If I think only about today, it's easier than if I think about the things that will never be. I always wanted a 50th wedding anniversary. We wanted another baby. That will never happen. I mean, I could have another baby, but **we** were going to have another baby.

CPHP: You still miss him a lot. **Beth:** Every day! Every minute! And some days, I get really angry and I think, "If I had (Continued next page)

to have him back the way he was, lying to me, that ... I wouldn't want him...." And then I think, "Oh yes I would!" I realize that I'd take him back for an hour. For a minute. Forever. Because—he didn't know. He just didn't know. It was too unbelievable that this was really happening to him. That his life was ending this way, when he'd had so much going, so much promise. When he was so young. Yet—how could it ever happen, that anybody so bright would not know? I'm still not sure I understand it, really.

CPHP: You know, it hasn't been that long. Beth: Things stick out.... Picking out the casket was horrible. I think that anybody who has an addiction, or contemplates suicide, should have to go visit a funeral home and pick out a casket for someone they love. It's an incredibly cruel thing to do to somebody. The decisions I had to make. Was I going to bury him or cremate him? I mean, I knew that everyone dies. But, to die at 28, with such an incredibly bright future ahead of him. Somebody so lucky. How could it happen to him?!

CPHP: This is still pretty painful for you, bringing all this up again. **Beth:** Yes. But in an odd way, it helps. It's

something you have to go through.

CPHP: It is very much appreciated. But let me ask, while we're on the subject, why do you do all these things? Speaking to medical groups? Giving interviews such as this one? Beth: Because nobody should have to go through this. Nobody should have to do this. Nobody should have to bury their 28-yearold husband, because they didn't know what addiction really does.

And that was me. I didn't know. And if Rick knew how serious this whole thing was, he either didn't want to believe it. He just couldn't hang on to the reality of where the addiction was actually taking him. Where it would end. And where it did end. Nobody should have to go through that.

CPHP: If somebody out there reads this article, someone who is addicted, or someone who loves someone who is addicted, and you could tell them one thing—what would that be?

Beth: That there are more important things than losing your medical license. Like, losing your life. **CPHP:** There's a bit of "what if" in this next question, but, for the reader—knowing what you know now, are there things you wish you could have done differently?

Beth: You have to be very careful when you allow your mind to start with the "what if" scenarios. It can be really dangerous. That leads to guilt. To the useless pain and the really dark times. And yet, you can't help asking yourself, "What if ...?" I would ask myself, even if you didn't.

Let's see: Given what I now know, I wish I would have called his Chairman. I didn't know about CPHP. If I could have had two things, and if I could go back, that's what I would have done—called his Chairman, and called CPHP.

CPHP: So, you think that, maybe if word gets out more about CPHP, so that people have it firmly in their minds that it's there....

Beth: If I'd known about it, and if I'd really believed that it was anonymous, and was really safe, I would definitely have called. Over the last year, I thought about calling any number of people, any number of times. But you're scared. You don't know who can really be trusted when someone suffers from this disease. I didn't know who was safe. And, in retrospect, I have to say one more time: I really didn't know how unimportant a medical license really is.

CPHP: Is there anything about the system of education that Rick was a part of that you think should change?

Beth: I think that maybe some people with this disease should think twice about Anesthesiology as a specialty. I imagine that Rick wouldn't agree with that. But maybe, for him, it was just too dangerous. At some point, you have to be able to stand up for yourself. You have to be able to say, "Maybe Anesthesiology isn't a good thing for me, with my disease. Maybe it's too dangerous for me to go into."

I think mandatory drug testing might not be a bad idea. Six months ago, I never would have said that. I would have fought for that idea tooth and nail. How dare anybody violate my constitutional rights and blah, blah, blah. But, I'm sorry! So your privacy is invaded? Once or twice. Big deal. You want to talk about invaded privacy? You should have reporters call you, wanting to know about your husband.

"So, tell me, was he an addict?"

"So, tell me, did he steal drugs from the hospital?"

That's invaded privacy!

CPHP: Does this interview feel a little like the same thing?

Beth: No, not at all. First of all, we're doing this for a reason. There's a purpose for this. And second, all they wanted was the dirt. They didn't know, or care about, where we met, that we went to the high school prom together. That we were high school sweethearts. That Rick was straight-A in college, and Phi Beta Kappa. All they wanted to know was, "Were the allegations true that he stole drugs?" All they wanted was the dirt. They didn't want to know that he was a wonderful daddy. And that he loved his children. And that he did a lot of good in his life, and helped a lot of people even in the short time that he was a doctor. They only wanted to know the negative part.

But, no matter how he died, it had no effect on the good he did. Or the good person he really was. In spite of everything, I have no regrets. If I'd have known twelve years ago that we would only have twelve years, I'd have done the same thing. In a heartbeat.

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This doctor didn't have to worry about who got elected to the legislature.

Photo: Living History Farms, Urbandale, Iowa

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IOWA MEDICINE Interview



Jose Angel, M.D.

Leading is better than following

The author, a Des Moines internist and member of the IMS Committee on Young Physicians, says involvement in organized medicine is crucial.

Why are you involved in organized medicine?

I am involved in organized medicine to lead the discussion rather than blindly accept outside decisions on how I should practice medicine. I believe health care reform is inevitable and unavoidable. Health care delivery and payment will change whether or not we accept the fact. The economic burden on our society is enormous, while the burden of the uninsured is ever increasing. This is a political and social problem which can only be dealt with through "appropriate channels."

Organized medicine, including the American Medical Association, has become the main source of physician input. It is my responsibility to affect the discussion. Politicians, economists and businessmen do not understand the importance of a physician's ethical mandate.

Currently, the federal government reimburses physicians in practice less than five years at a lower rate than other physicians. How is this affecting young Iowa physicians? What is organized medicine doing to correct this inequity?

Young Iowa physicians are feeling the pinch of reduced reimbursement. As individuals starting small groups or in solo practice, they are less able to bear the high start-up costs of private practice. Thus, many are choosing to work for salary in larger groups. In addition, large groups have reduced reimbursement to starting physicians due to the reduced income generating potential of these young physicians.

The Iowa Medical Society and the AMA have taken a very proactive stance on this issue. They have argued that it is unethical to pay young physicians less because the government is in a fiscal crisis. Legislation has been presented to both the House and Senate and has been favorably received; it is anticipated this situation will be reversed in the near future.

(Continued next page)

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All Iowa physicians under one umbrella...



Today and tomorrow, the IMS belongs to you

If you are a physician practicing in Iowa, the Iowa Medical Society is your organization. It's the only organization which represents all Iowa physicians...students, residents, women physicians, young physicians, established physicians, minority physicians and physicians is all specialties. The cover photo of IMS members shows the increasingly diverse group covered by the IMS umbrella.

We can be proud that 82% of Iowa physicians belong to the Iowa Medical Society...proud that so many Iowa physicians feel a responsibility toward their colleagues and their profession. Seventy-five percent of IMS physicians support all three levels of organized medicine—their county medical society, the IMS and the AMA.

Despite their diversity, Iowa physicians have pretty much the same concerns. Providing the highest quality medical care possible. Ensuring access to care for all Iowans. The freedom to practice without burdensome regulations. Fair health care legislation and equitable reimbursement. These issues are on the minds of Iowa physicians and on the agenda of the Iowa Medical Society.

When you join the IMS or renew your existing membership, you are investing in your future. Read on. You might be surprised at the number of ways the IMS is working to improve the environment in which you and other physicians practice.



IMS is your voice in the Iowa Legislature and with governmental agencies

*When the Iowa Legislature is in session, IMS public affairs staff and legislative counsel are there working for laws which benefit patients and improve the environment in which physicians practice.

*The IMS has strong representation with the Governor's office, the Iowa Department of Public Health, the Iowa Insurance Division, the Department of Human Services and other agencies.

*The IMS continues to advocate a comprehensive public health legislation initiative which includes tobacco use reduction, fireworks safety and AIDS policy.

*The Iowa Medical Political Action Committee con-

tinues its crucial involvement in local, state and national elections. This committee scrutinizes the qualifications and platforms of all political candidates.

*IMS member physicians represent the pro-

MS quick fact #1

*Without IMS efforts in the Iowa Legislature, a .5% tax on your practice revenues would have been enacted to help balance the 1993 state budget.

IMS quick fact #1

fession on health care committees and task forces appointed by the Governor or the Iowa Legislature. These committees formulate policy recommendations on Medicaid cost control, rural health care and other issues.



IMS is your voice with third party payors and allied health organizations

*IMS staff assist physician members with problems relating to third party payors, Medicare and Medicaid. The IMS maintains solid working relationships with Blue Cross/ Blue Shield, Principal Financial Group, etc.

*The IMS is active in representing physicians' concerns with other health provider groups such as the Iowa

Hospital Association, the Iowa Nurses' Association, the Iowa Pharmacists Association, etc. IMS physicians are involved in discussions with outside organizations regarding reform of our health care system.

*The IMS has cre-

IMS quick fact #2

★ IMS leadership on public health issues such as substance abuse, AIDS and traffic safety has increased the public's respect for all Iowa physicians.

IMS guick fact #2

ated a committee to help members deal with concerns regarding the Iowa Foundation for Medical Care, Iowa's peer review organization.

*The IMS has excellent liaison with the University of Iowa College of Medicine.

*The IMS maintains active relationships with the AMA, county societies, specialty societies and the Iowa Medical Group Management Association.



IMS is a source of information you need in today's complex environment

*IMS members receive several newsletters which contain information on many subjects of interest to Iowa physicians. The IMS MEMBER REPORT is sent monthly to IMS members and discusses general topics including activities of IMS officers and committees and timely developments in health care delivery.

*The IMS STATEHOUSE REPORT is published periodically during sessions of the Iowa Legislature and keeps member physicians apprised of developments in the area of health care legislation.

*The IMS WASHINGTON REPORT, also published periodically, informs members about Congressional activity of interest to physicians.

*Iowa Medicine, Journal of the Iowa Medical Society,

is sent monthly to all IMS members. The magazine contains articles exploring socioeconomic developments in medicine, scientific topics, physician editorials and practice management advice. The magazine contains a classified advertising section and a physicians' directory.

*The extremely successful IMS LEGISLATIVE HOTLINE allows physicians across Iowa to call an 800 number and get the very latest information about legislative activity.

*IMS MINI-MESSAGES are sent to member physicians or legislative contact physicians when a crucial legislative or regulatory development occurs.

*The IMS Go-Between Report, the newest IMS newsletter, explores issues relating to government regulation, third party payors and Iowa's PRO. This newsletter offers much valuable advice to member physicians.

*An IMS Membership Directory containing the names, addresses and phone numbers of all IMS members is provided annually to physicians, hospitals, libraries, chambers of commerce across Iowa and others.

*The IMS has position papers on a number of key legislative health care issues which are available for any IMS member.

*The IMS regularly provides informational brochures, flyers, etc. to its members. The most recent example is a file folder of information on health care reform which was mailed to all IMS members. The folder included position papers and information physicians can use to educate patients about state and national reform proposals.



IMS provides educational opportunities in science, socioeconomics

*The IMS is involved in many continuing medical education activities. A Scientific Session is held in conjunction with the IMS House of Delegates meeting. This session covers the latest medical techniques and socioeconomic and ethical issues important to Iowa physicians.

*The IMS is an accrediting agency for continuing medical education for institutions across Iowa.

*Iowa Medicine publishes scientific articles written by IMS member physicians on a wide range of topics.

*Every year, the IMS sponsors seminars and programs

IMS quick fact #3

* Without Medicare Partners, the IMS voluntary Medicare assignment program, Iowa legislators would have enacted mandatory Medicare assignment for Iowa physicians.

IMS quick fact #3

designed to help physicians improve management of their practices or learn about issues affecting health care delivery. A recent example is a series of seminars on advance directives sponsored by the IMS and the Iowa State Bar Association



IMS is concerned about the public's opinion of physicians

*The IMS coordinates media interviews with physicians on health topics. IMS physicians are well-respected and are instrumental in filling the public's growing appetite

for health information.

*IMS officers and staff meet with the editorial boards of major newspapers on key health care issues such as medical liability reform.

*The IMS sponsors training sessions for physicians across Iowa who will be the Society's me-

IMS quick fact #4

* Hundreds of Iowa physicians depend on seminars sponsored by the IMS and advice from IMS staff members in coping with Medicare payment reform and new OSHA and CLIA regulations.

IMS quick fact #4

dia spokespersons on important health care issues.

*The IMS produces materials for public education on important health care matters such as the new Durable Power of Attorney for Health Care.

*The IMS regularly seeks media coverage for various public health projects involving member physicians.



IMS is concerned about the health of all lowans

*The IMS has implemented a voluntary Medicare assignment program, "Medicare Partners", which addresses the health care needs of the elderly.

*Various IMS committees are involved in projects designed to improve the health of Iowans of all ages. These projects have included educational materials on identifying and reporting child abuse and AIDS pamphlets.

IMS guick fact #5

* New federal loan deferments and forebearance provisions have been negotiated for medical students and residents by organized medicine.

IMS quick fact #5



IMS is preparing to help you meet the challenges of the future

*IMS officers, physicians and staff are involved in strategic planning designed to assure the IMS is prepared to meet the needs of its members in the future. Four committees are developing strategies for communicating more effectively with physicians and the public, promoting membership in organized medicine and building coalitions to be more effective advocates for all IMS members.



IMS SERVICES— SUPPORTING IOWA MEDICAL PRACTICES THROUGH PEOPLE AND PROGRAMS

The right combination is needed if today's medical care challenges are to be unlocked and dealt with successfully. At IMS SERVICES, we think we have the right combination — informed people and sound programs.

As a subsidiary of the Iowa Medical Society, IMS SERVICES has combined people and programs to reflect its commitment to helping IMS members and their staffs deliver quality care in complex times.

Pictured here is the people component of IMS SERVICES. They constitute a portion of those who serve as staff under the Iowa Medical Society unbrella. IMS SERVICES employees are pledged to conscientiously and efficiently assist IMS members.

Proof that IMS SERVICES is succeeding is seen in the fact that 3 out of 4 Iowa physicians—or their practices—participate either in one or several of our programs.

What areas of programming are offered by **IMS SERVICES**?

Practice management advice

Whether it's individual practice consultation or an information/education program, IMS SERVICES is delivering help to Iowa physicians and is getting good feedback on its expanding activity in the areas of reimbursement, coding, billing, OSHA, CLIA and patient relations.

Staff expertise is built by contact with various resources. Answers and solutions are furnished to practice-specific inquiries and beyond in special workshops and conferences.

Assistance with insurance needs Since IPMIT was founded in 1985, IMS SERVICES has served as its



IMS SERVICES staff

captive agency. IPMIT insureds are counseled on coverage questions in coordination with IPMIT staff. Increasing the number of IPMIT insureds has been an IMS SERVICES responsibility; the policyholder count has risen to 1,200, which is double the insured count at year-end 1985.

Other insurance programs are furnished in various areas—health, life, disability, workers compensation, annuities. Sponsored coverages are selected for their stability, benefit features and cost-effectiveness.

Help for specialty groups

A rapidly growing **IMS SERVICES** support activity is helping Iowa medical specialty groups carry out their organizational programs.

Administrative/executive assistance is supplied to the psychiatrists, oncologists, long-term care facility medical directors, physiatrists, radiologists, anesthesiologists and, in the near future, cardiologists.

IMS SERVICES facilitates the important work of the 450-member Iowa Medical Group Management Association. IMGMA is a group of dedicated individuals who work in medical offices/clinics across Iowa.

And that's not all

Each year, additional programs are initiated to serve physicians and their practices. There's a billing and collection service, a long distance telephone discount program, a credit card program, a subscription service and a car rental discount program. The major new activity is called ARMS.

Who you gonna call?

One of the people pictured here will furnish information on any program mentioned. Direct your inquiries to IMS SERVICES, 1001 Grand Avenue, West Des Moines, Iowa 50265 or telephone 515/223-2816 OR 800/728-5398.

ARMS is the newest IMS SERVICES program...

Begun in 1992, ARMS is a practice support program for offices and clinics created and administered by IMS SERVICES. The acronym stands for Accounts Receivable Management Services. Through electronic filing, ARMS will submit insurance claims for its client practices on an economical basis. ARMS is also equipped to collect, organize and report practice-specific data of major importance.



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Opiate addiction in Iowa

Where do opiate addicts obtain drugs? Interviews with patients in an Iowa methadone clinic reveal some surprising responses with definite implications for physicians who prescribe.

Daniel Murphy, M.D.

Cedar Falls, Iowa

POR THE PAST SEVEN YEARS, as part of my family practice in Cedar Falls, I have operated one of only two methadone maintenance clinics in Iowa. Beginning with a single patient in 1984, the program is currently treating 55 individuals. This has given me substantial experience in dealing with the issues surrounding drug addiction and treatment. I will discuss what I have learned operating the program and suggest ways in which Iowa physicians can better identify and deal with opiate addiction.

The spread of AIDS by contaminated needles, by sexual contact and by transmission across the placenta is a relatively new and important consideration begging for attention. The timeliness of this subject is highlighted by Dr. James Cooper of the National Institute on Drug Abuse (1989): "In contrast to New York City, NY, where enormous personal tragedy and public health costs from AIDS are inevitable, cities where HIV infection is low or nonexistent still have a brief window of opportunity in which to implement prevention efforts."

The biographical information and statistics in this article are based on anonymous and voluntary interviews with 46 addicted patients

conducted over a two-month period in early 1992.

Can't control addiction

This program's patients come from all walks of life, including the health profession. The oldest addict is 53 and the youngest 21. The median age of this group is 37, a relatively advanced age. Many younger persons frequently use cocaine, a stimulant. They are seeking excitement and action—the "high." In contrast, an individual who is ready to slow down turns to opiates. People who use opiates spend their time quietly "nodding," usually alone.

Characteristically, most patients coming into this program have failed at multiple traditional attempts to control their addiction. Methadone blocks the craving they have lived with for years. It is a semi-synthetic, long-acting, oral narcotic which, taken daily, allows a patient to function normally. Properly dosed methadone used for maintenance neither sedates nor produces a "high."

In the seven years of the program's existence, several patients with relatively short histories of opiate abuse have successfully undergone detoxification from methadone. Short term addiction is easier to stabilize and detoxify both physiologically and psychologically. Others await a more meaningful rehabilitation in their lives in the areas of employment, education and interpersonal relationships before

Dr. Murphy maintains a family practice in Cedar Falls.

THE IMS EDUCATION FUND HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION AWARD FOR NOVEMBER 1992

attempting detox. A number of patients have failed to continue the methadone program for various reasons.

Within this sample of 46 patients, there are 33 Whites (72%), 12 Blacks (26%) and one Hispanic (2%). Sex distribution is 15 females (33%) and 31 males (67%). Iowa county of residence for these 46 patients reveals a concentration of patients from Black Hawk County (18 or 39%) and Polk County (21 or 46%). Two patients (4%) live in Winneshiek County, and one each (2% each) live in Adair, Grundy, Keokuk, Marshall and Wright counties.

Level of education attained ranges from 7th grade to college graduates, with the median patient (20 in number or 43%) having a high school diploma only. Nineteen (41%) have formal schooling beyond the high school diploma,

'Most of those interviewed felt doctors are too easily persuaded to write prescriptions for pain pills, especially those that can be injected.'

with 16 (34%) having some college or university credit. Only 7 (15%) had less than a high school equivalent degree.

Prior drug use

Of the 46 patients interviewed, the number of years of "drug usage" ranged from two to 28; the median was 14 years. The median age usage began was 20. The youngest age for patient initial drug usage was 10; the oldest was 48.

When asked what three drugs were abused most frequently prior to treatment, 34 (74%) of the patients mentioned heroin. Twenty patients (43%) named Dilaudid and 15 (33%) said Percodan. In response to the question of which drugs, in addition to the top three, were used occasionally prior to treatment, cocaine was named by 12 (26%), marijuana 9 (20%) and codeine 7 (15%).

The financial ramifications of drug usage are staggering. The highest daily cost of an illegal habit was \$800. The lowest daily amount was \$20 and the median of all responses was \$120. Projecting the 55 patients currently in this program spending an average of \$120 per day

TABLE 1
ACTIVITIES TO SUPPORT DRUG HABIT

Type of Activity	Responses	
Boosting*	25	(54%)
Selling/dealing	30	(65%)
Burglary/stealing/robbery	13	(28%)
Prostitution	3	(<1%)
Scam doctors	19	(41%)
Forgery	3	(<1%)
Hustling	1	(<1%)
Other scams	1	(<1%)

^{*}Shoplifting and returning merchandise for cash.

on an illegal drug habit, the amount totals \$6,600 spent daily or about \$2.4 million in one year.

Supporting illegal habits, sources of drugs

Table 1 shows how addicts support illegal habits. One patient related burglarizing only veterinarian offices, sometimes travelling hundreds of miles a night to find opiates. Another easily supported the addiction of shoplifting cartons of cigarettes, mostly from convenience stores, then fencing them at another "convenient" store. "Boosting" merchandise for cash and buying and selling illegal drugs were the top money-makers.

Mentioned third, and by 41% (19) of the addicts, was scamming doctors for drugs to take or to sell for cash for other drugs. Scams mentioned often were faking pain, reading PDR's for symptoms to describe, being a nuisance patient so a prescription would be written to keep him/her away, stealing prescription pads or obtaining DEA numbers and calling in prescriptions.

In answer to the question regarding the source of pharmaceuticals, "doctors" was the most frequent response (18 or 39%). The next choice was a "dealer" (14 or 30%) and third (13 or 28%) was "on the street." When asked where street dealers get pharmaceuticals, 19 (41%) patients reported that pharmacies or drug stores are burglarized. Another 10 (22%) said burglaries or break-ins in general.

The number of weekly criminal infractions admitted by these 46 patients before seeking treatment demonstrates the burden imposed on society. Fourteen patients (31%) reported more than 30 crimes per week to support his/her habit. One patient (2%) estimated 16-30

crimes per week and another 13 patients (28%) said 6-15 weekly crimes.

Response to treatment

At the time of the interviews, time on the program varied from five days to seven years. The median duration of treatment was just over one year.

Patients in the program demonstrate significant changes in both behavior and quality of life. Thirty-eight patients (83%) reported no further crime after beginning treatment with methadone. Of the 14 patients (30%) admitting to greater than 30 crimes per week prior to treatment, 11 (79%) claim no criminal activity

since beginning the program.

There is also a dramatic decline in reported use of opiates after beginning the program. When asked of the frequency of illegal drug use since beginning treatment, 17 patients (37%) reported "never" using illegal drugs. Eighteen patients (39%) reported illegal drug use one time per month or less, with a number describing their current use as "twice in my two years on the program" or "one to two times in the last year." Eleven (24%) admitted they still use more frequently than one time per month, but they stated this typically is non-opiate drug use (cocaine, marijuana), a craving methadone does not counter.

To give another perspective on rehabilitation, answers show 29 patients (63%) are working, nine (20%) are in school with three others in the process of enrolling and eight (17%) are permanently or temporarily disabled. There is one homemaker (2%) and four patients (9%) were unemployed.

Physicians often tricked

Various pharmaceuticals are reported readily available in Iowa to fill the need when heroin is scarce. Apparently Iowa physicians are often inveigled! Ranges in street price for the pharmaceuticals in highest demand are listed in Table 2. Note that Dilaudid is gold on the street. Percodan, MS Contin and methadone are all frequently abused and can all be injected intraveneously. (The methadone used in this program is mixed with an acid-based juice which prevents its injection into a vein.)

Interestingly, although the pharmaceutical representative said MS Contin is formulated so as to make injection impossible, I have had numerous patients describe to me how easy it is to peel off the outer coat of "purple cows,"

TABLE 2 STREET PRICE FOR PRESCRIPTION DRUGS

Drug	Street Price
Dilaudid	\$10/mg
Percodan	\$3-\$5 each
Tylenol with codeine	\$1-\$2/pill
M.S. Contin	\$15/purple cow
	\$25/orange
Methadone	\$1/mg
Tussionex	\$10-\$40/oz

dissolve the contents and inject the morphine. Percocet, Tylenol with codeine and Tussionex cough syrup cannot be injected but are sought after by many.

What can Iowa physicians do? Be aware! Needle marks over veins, hepatitis, HIV positivity, abscesses over veins and especially patient prompting which leads the discussion toward opiates should all raise suspicion. Most of those interviewed felt doctors are too easily persuaded to write prescriptions for pain pills, especially those that can be injected.

Moreover, opiates may not be a good solution to chronic pain, as many patients develop tolerance to the therapeutic effects. (A number of patients on this program say their addiction began after opiate treatment for genuine pain.) I rarely prescribe more than 20 tablets of any opiate at one time and require frequent followup. Also, be aware that cancer patients, people with long-term disabling conditions, and their family and friends have been known to sell opiates prescribed by Iowa physicians. My patients tell me these sources are common.

Prescribe judiciously

Iowa physicians can reduce drug abuse and the dissemination of AIDS, by judiciously prescribing drugs which may be used intranveously. A high index of suspicion will help identify potential abusers. In addition, appropriate use of methadone is one tool found to be useful in treating opiate addiction in Iowa.

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Hippocrates at graduation

Richard M. Caplan, M.D.

ISTENING ONCE AGAIN to the graduating Imedical students repeat the Oath of Hippocrates, I let my eve follow the words printed in the program. This version of the oath I knew to have been "contemporized" because it did not oblige the oath-taker to promise never "to cut for the stone." Just which modern version lay at hand was not

identified on that program.

The word "science" did not appear, but the graduates swore to "practice my art in uprightness and honor." Not only "practice my art" that way but "lead my life" that way. I wonder if all the students grasped that implicit fusion of their lives with their medical practices. If not, they soon will. "The art" was mentioned once more: "I will exercise my art solely for the cure of my patients" If one indeed strives only (and always) for cure—as opposed to palliation or care—the implications are enormous in behavior and cost. If the translation had promised to do "what is in my patient's best interest" rather than strive "solely for the cure," one might feel more content. These nuances may seem unimportant to some who set aside such distinctions as "just semantics." I puzzle and object at the tone of dismissing-atriviality in that "just."

In a news item of June 30, 1992, Iowaborn Dr. Thomas Starzl, transplant pioneer, defended his world's first baboon-to-human liver transplant against animal-rights activists by saying, "Our passion and our commitment is to human beings. We took an oath when we graduated from medical school to do that." Let me first assume the quote is correct (perhaps assuming much). I can't tell whether Dr. Starzl usually speaks of himself in the first-person plural, whether he believes himself speaking for his "team" at the University of Pittsburgh, or whether he believes he is empowered to speak for the entire medical profession of this country, or the world. More to the point is my surprise that he calls upon some version of the Hippocratic Oath. I know no version of it that speaks at all to our obligations, if any, to any life forms other than our patients. In Ancient Greece it would have been assumed, I assume, that physicians had no special relation or obligation to animals of any sort other than was felt by persons-in-general of that time and place. That would seem to account for the lack of mentioning them in the Oath.

Perhaps most to the point is the fact that Dr. Starzl appeals to that ancient oath as justification for his behavior today. Perhaps he feels deeply and totally bound by those words he swore as a young physician. (I wonder if he also swore never to cut for the stone. Perhaps being a transplant surgeon finesses that problem neatly.) Or perhaps Hippocrates merely provides him a convenient defense against attackers whose values so differ from his own. I come neither to praise Starzl nor bury him—nor Hippocrates either. More than anything, I marvel at the persistence of some old ideas and traditions and their power to influence contemporary

thought and behavior.

But ideas, too, like biological entities and maybe even like stars, seem to have a life and death. Even the Hippocratic vow to confidentiality of patient information is weakening in our world of multi-specialists, large hospitals and computerized information systems. What Hippocrates said about cutting for the stone, performing abortion and revering one's teachers has lost much of its authority. To revere tradition is wonderful but to adore it may become problematic. The Oath's complete absence of comment about a physician's obligation to society has also brought it many new critics. I'm left wondering whether Dr. Starzl wears his toga and sandals while operating, or only outside the hospital.

Dr. Caplan is Coordinator, Program in Medical Humanities at the University of Iowa College of Medicine



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Practice and Personal Management

Physician involvement in accounts receivable

IN MEDICINE, VITAL SIGNS serve as key indicators of a patient's overall condition. There are also vital signs which determine the financial health and vitality of a medical practice. The most important of these signs is accounts receivable.

Accounts receivable are more important than charges because charges often are not completely correlated with receipts and practice income. Accounts receivable are also more important than cash receipts because receivables are a true indicator of overall bill-

ing efficiency and effectiveness.

For example, in a growing practice receipts will probably be increasing, which is a good sign. However, if accounts receivable increase faster than receipts there could be a problem collecting for services rendered. An exception may be if your practice is growing rapidly because new services or a new physician may have been added. In any event, you will need to know why accounts receivable are increasing.

Daily monitoring

The first step is to accurately measure the receivables. Monitoring the level of accounts receivable on a regular basis is important. Daily reports should be prepared which balance all charges and payments to services provided.

How should the physician participate in accounts receivable management? First of all, a written payment policy should be given to all patients. If you do not currently have such

a policy in place, establish one.

A payment policy outlines the patient's responsibility for paying for the medical services provided. It will also indicate what services you will provide, such as filing insurance claims. It will name carriers with whom you have contractual agreements. In addition, the payment policy will explain the

This article was written by Mary Ann Crawford, president of Consultants for Better Business, Inc. in Des Moines. A former office manager, Ms. Crawford is a member of the Iowa Medical Group Management Association.

financial obligation that is the responsibility of the patient at the time of service.

Every employee, including the doctor, should know the policy and communicate with patients and the billing office in a consistent professional manner.

Proper coding

Secondly, precise documentation which allows the highest level of coding is essential to good reimbursement. Claims which are properly coded stand the highest chance of correct payment upon submission. When claims are paid the first time around, cash flow is better and accounts receivable consist of more recent services. Who can better document and code than the physician who provided the service?

Hire an experienced, qualified billing staff with an understanding of accounts receivable and cash flow. Once that staff is in place, continuing education is a must. Changes in billing requirements and related new information are published on an almost daily basis.

Age billing date

Also, of utmost importance is a good automated system that will age by the date billed to each responsible party and will reage as the balance due transfers to each new party. This aging method allows your staff to follow up on receivables with each carrier and patient and to know how long charges have been out to each responsible party.

In the ideal situation, the practice bills each insurance carrier at least weekly. Depending upon the specialty and the number of people on the billing staff, it may be possible to bill for all services on a daily basis. Successful management of accounts receivable depends upon keeping all billing up to date.

As the physician owner of the medical practice, you'll want to communicate with your staff and give them the tools they need

for you to reach your goals.

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Donald Clark, M.D., 65, anesthesiology, Waterloo, died May 11

Charles Semler, D.O., 78, family practice, Story City, died May 21

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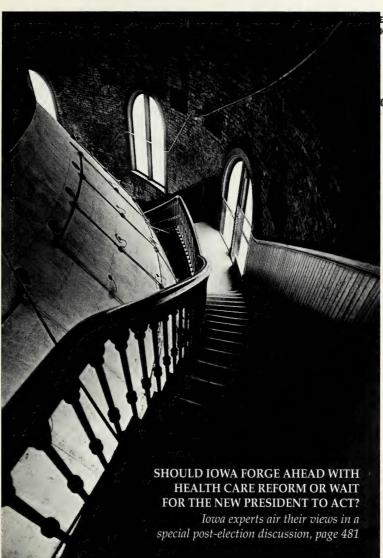
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Quo Vadis

In his biographia Literaria in 1817, Coleridge said "every reform, however necessary, will by weak minds be carried to excess, that itself will need reforming." Nothing could be more true 175 years later with regard to health care reform. There can be no question that reforming health care could create such chaos the entire system would suffer. At the same time, physicians must advocate those reforms which benefit the delivery of health care and discuss the implications of certain other reforms with our patients—the public.

The pay-or-play provision for the financing of health care is a dual insurance system in which an employer provides health care insurance to employees or pays a tax—usually at least 7% of gross payroll—to a fund from which those uninsured employees are then provided insurance through a governmental agency. It is important for the public to realize that pay-or-play financing of health care

will lead to a single payor national health insurance.

Expenditure targets or global budgets—terms used to describe caps on the expenditures for health care—must be accompanied by effective control of the demand for health care to protect the health care delivery system from collapse by overuse. Americans have demonstrated an insatiable appetite for health care and are willing only to control health care services when it affects others rather than themselves. Unless the demand can be controlled and that control freed from the medical liability review systems, the health care systems may be permanently crippled by price fixing.

A standard benefits package, incentives for primary care and support for preventive medical techniques are additional reforms to bring to the public, our patients, so they can make independent informed decisions on health care reform. We owe it to our profes-

sion and the public we serve.









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The Editor Comments



Marion E. Alberts, M.D.

Strive for better education

WE OF THE MEDICAL PROFESSION are fortunate in the educational opportunities we have had. Our education never ceases, for only through continuing education may we retain our license to practice in Iowa. Many states have similar regulatory provisions to retain a license to practice medicine. Because of our educational background our children likewise, for the most part, are well-educated.

Recently a series of statistics about the state of education in America came to my attention. "Attention" is an appropriate word because those statistics made me fully realize the sad state of our American educational system . . . or the lack of it for many.

One in five (20%) of American adults is functionally illiterate. Approximately 27 million adults are considered illiterate and 45 million marginally illiterate. It has been estimated this illiteracy costs American businesses and tax payers \$20 billion annually.

Within the next few years, 93% of the largest U.S. corporations will be training their workers in fundamental work place skills. It is shocking that workers are under such handicaps to productivity. Another estimate has been projected that 25 million Americans cannot read and 35-40 million read below the ninth grade level. It is no wonder so many are unemployable . . . they cannot complete applications for employment and if they are hired, they are unable to read and understand written materials presented to them.

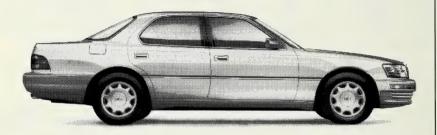
Fifty percent of Americans say they do not read books. A 1985 study of adults age 21-25 demonstrated 73% could not understand a newspaper story and 63% could not follow written map instructions.

What can be done? How does this concern the medical profession? We see people from all walks of life in our daily practice. We can be instrumental in urging youngsters to stay in school and reap the benefits of an adequate education. We should work with our school boards and teachers to foster good education facilities. The U.S., by one estimate, ranks 14th among 16 industrialized nations in the percentage of the gross national product spent on education. We must foster increased interest in education for all.

Most Americans—96%—with children in public schools say they are concerned about the quality of education. But, that unfortunately is mostly lip-service because only 25% of parents visit their children's schools.

As we enter another four-year term following a hectic presidential election, let us as educated people make a concerted effort to foster better education for children and adults. Work for excellence. Urge better systems and incentives for an education. We are examples of the values of good education. We need to emphasize the value of a good education at every opportunity. It will make our country an even better place in which to live.

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Health care reform: what will happen under the Clinton administration?

America will have a new president in January, but no one is quite sure what he plans to do about health care reform. IOWA MEDICINE assembled a panel of experts two days after the election to prognosticate about health care reform in Iowa under a Democratic administration.

Editor's note: Participants in this special post-election discussion of health care reform included: Christopher Atchison, director of the Iowa Department of Public Health; Elaine Szymoniak, Democratic state senator from Des Moines; Paul von Ebers, senior vice president of health care management for Blue Cross/Blue Shield; Bruce Trimble, M.D. of Mason City, a member of the Iowa Leadership Consortium; and William Eversmann, Ir., M.D. of Cedar Rapids, IMS president. Some of the discussion centered around the work of the Iowa Leadership Consortium, a task force of 14 representatives of diverse groups working on a plan for health care reform in Iowa. (The ILC is proposing a workplace-based insurance program with individual mandate, per-capita expenditure targets, fee schedules and creation of an Iowa Health Commission with extensive authority to oversee health care delivery.) The discussion was led by Marion Alberts, M.D., IOWA MEDICINE scientific editor.

DR. ALBERTS—Now that the elections are over, what do you think will happen with health care reform?

DR. TRIMBLE—President-elect Clinton emphasized in his post-election speech that this will be one of his major themes. I think we are going to get health care reform that will focus on controlling costs as well as improving access.

CHRIS ATCHISON—I think the election shifted the focus. I think under the Bush administration you had a primary focus on the cost side, the market side of health care. Clinton will bring more emphasis to the access side, focusing on the uninsured and under-insured population.

ELAINE SZYMONIAK—I think it's important to recognize that Clinton has been a governor and is aware of how things work in states. I asked him six months ago if he felt states should move ahead with their own plans or if reform should occur only at the national level. He said states should move ahead. I think there will be a role for states to do some experimenting. I suspect that Oregon will be granted its waiver. In a country as diverse as this one, it will not be easy to come together with a plan that will be comprehensive.

DR. EVERSMANN—I believe the only thing we can say for certain is that his plan will include some sort of federal regulatory commission. It could be designed to coordinate state efforts or to coordinate federal and state efforts. Certainly the needs of a state such as our own are different than a state such as California. We might look for a federal plan to give us some guidelines in certain areas, but I think the nuts and bolts of the plans will be

(Continued next page)

left to the states. There is ample room to continue to look for those qualities of a health care reform that would benefit the state of Iowa.

PAUL VON EBERS—It's not totally clear to me whether we're going to have a central focus on the federal or a state level under the Clinton administration. Secondly, I think the details of a Clinton plan have yet to be worked out. It does seem clear that he's talking about



'Many of us commit ourselves to medical practice because we feel a responsibility to the people of this state and we are not discussing health care reform purely for the protection of our own assets.'

> William Eversmann, Jr., M.D.

a federal agency to set some target expenditures. He is also talking about a mandate for small employers; however, he's also talking about tax credits and we don't know the size, extent or the time frame of those tax credits yet. It may turn out that the ILC plan is more acceptable to small business than the Clinton plan. Iowa has never done well under a federal health plan.

DR. EVERSMANN—Iowa has generally fared poorly under health care regulation at the federal level. I think this should give us some motivation to continue to work at the state level because we have no political clout at the federal level. At the same time, I think we have some unique problems.

CHRIS ATCHISON—I agree with Dr. Eversmann—there is a clear indication by President-elect Clinton that he's going to establish baseline standards operating through some type of national health commission. How he achieves that is one of the hurdles. As president he has significant power but he does not have omnipotent power. I think you will see in Governor Clinton a recognition of the states' need for latitude within the waiver process. The other issue is the ERISA (Employee Retirement Income Security Act)

changes which are holding up plans in a number of states including Minnesota. That is something the president will not be able to unilaterally change since it will require congressional action. It's terribly important that issue is resolved because waivers are aimed primarily at the Medicaid population. ERISA gets at how can we arrange the financing to cover the cost of health care for the uninsured.

PAUL VON EBERS—We have a president who is going to push an employer based system. That probably means you need a change in the ERISA law. In terms of state direction, we basically have three generic approaches to debate, one being a single payor system which I would suggest has been largely rejected. The other two alternatives can both be employer based if they need to be. They could be similar to the ILC proposal which would include some government oversight of the system but also could be much more like a market competition approach.

ELAINE SZYMONIAK—I think the single payor plan is out of the picture, certainly in the Iowa Legislature. There is not a great deal of understanding of health care in either house. I think the committee that is studying Medicaid is going to come out with some recommendations relating to long-term care that may require waivers. Perhaps we can have some meaningful Medicaid reforms which could take effect quickly since there is great pressure to do something to hold down Medicaid costs.

DR. TRIMBLE—Both Clinton's proposal and the Democratic Conservative Coalition proposal envision stimulating purchasing coalitions or organized delivery systems. I hope Clinton—with his knowledge of governing a state as well as the personal relations he has with governors of many states—realizes the necessity of individualized plans. It also appears that if we're going to have strong emphasis on cost control in the form of a capping mechanism, it would be much easier to operate that mechanism on a state level.

Dr. Alberts—Is there a consensus that Iowa should move ahead immediately?

Dr. EVERSMANN—We who have talked about health care reform in a variety of venues have learned not to use the word consen-

sus. I think there is unanimity of opinion that the state should function in health care reform, even if the function is something as simple as Medicaid reform.

CHRIS ATCHISON—I agree entirely. I envision some type of national direction system developing, but the federal government has a real difficult time dealing with the reality of service delivery on the state level. Unless Iowa determines how best to carry out its health services, we're going to live with some national policy that may not work here. I think president-elect Clinton is sensitive to that. His state shares middle American dynamics and he isn't just going to respond to urban needs for health care.

ELAINE SZYMONIAK—We could set a pattern for other rural states.

PAUL VON EBERS—The Medicare Fee Schedule is not working well for Iowa. We've never been paid appropriately by the Medicare program for either physicians or hospitals and I don't think we should assume Iowa is going to do better in this administration than in a Republican administration. If we're going to have some additional government involvement in health care, we don't want to use HCFA as the model. So it's important for us to be active at the local level to make sure we don't get that.

DR. ALBERTS—What's the timetable for the ILC?

PAUL VON EBERS—I think our first task is to better understand the Clinton health plan so we can figure out how to respond. I think we're going to have to develop a new time frame. Many of us would like to see some action on health reform in 1993 but the national scene may intervene.

DR. EVERSMANN—It seems to me we could anticipate no significant action from the ILC or the legislature in 1993. Let's presume the Clinton plan requires 100 days. If I count 100 days from January 20, we probably are past the time the legislature could act unless the session is extended far beyond usual. Once again the ILC would be working into May or June.

PAUL VON EBERS—I just think there must be more consensus building. Clearly, we aren't going to finalize the work of the consortium

'If we're going to have some additional government involvement in health care, we don't want to use HCFA as the model.'

Paul Von Ebers



in the next 30 days. Certainly, any plan has to be signed by the governor so I think we need to be responsive to his needs. However, we could set a schedule that would help us arrive at a political consensus during the next session.

ELAINE SZYMONIAK — Will there be a decision about what part of the ILC proposal could be a starting point?

PAUL VON EBERS—I think we should do some of the work in stages. It may be difficult to do everything at once. However, a lot of participants in the ILC are very worried about unhooking the access issue from the cost containment issue.

DR. EVERSMANN—The difficulty I see in the negotiating process is that the various constituencies may feel their needs are being disregarded while others are being met in the course of a piecemeal approach to reform. Unless we can find a few items which are so clearly beneficial or neutral to all of the participants, it's going to be hard to separate items.

DR. TRIMBLE—Senator, do you have any feel as to whether the new legislature is likely to take up health care reform outside the ILC?

ELAINE SZYMONIAK—No. I think the group that has pushed single payor might continue to do that but they're going to have less power than they had before.

DR. Alberts—What kind of feedback are we getting from the public? Do they understand what we're talking about?

ELAINE SZYMONIAK—No, they don't understand at all, but they are very worried. The

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thing I've picked up listening to people is a great deal of fear about losing their coverage if they lose their jobs. I talked to people who are locked into jobs they don't like because they don't dare leave.

PAUL VON EBERS—National polls say that if you propose any plan, 70% of the people say they are for it. If you propose a single payor system 70% are for it, if you propose a free market system, 70% are for it. That tells me people want change and they're looking towards people in leadership positions to come up with a plan.

DR. EVERSMANN—The thing that concerns me about the public is those who have insurance now are not interested in many of the essential facets of health care reform. The average person who already has some insurance doesn't feel the urgency to increase access that he would feel if he were uninsured. The



'I don't think we're ready to do anything in the legislature because we aren't educated enough about possible solutions.'

Elaine Szymoniak

public wants to control cost, yet they don't want to line up for care. A health care delivery system that can satisfy that need may be a little more costly. Also, the public appears willing to control the demand for health care for their neighbors but not for themselves. We have to increase their understanding of their own participation in the health care system.

PAUL VON EBERS—Any reform is going to require that everybody give a little to get a little. That includes consumers.

ELAINE SZYMONIAK—I think that is absolutely fundamental to anything we do. People expect the latest technology. They have no concept of what their role has been in driving up costs. Who's going to help people

think this through and begin to take some individual responsibility?

Dr. Trimble—People have to realize that health care reform will be a series of tradeoffs. However, it's our obligation to accept a leadership role. I think this is an area where the public is looking for leadership and we would make a mistake in being fearful of people's reactions. If we don't make rational reform we're going to have irrational reform. Physicians can do a better job examining practice patterns that are cost effective but I think we need to be very careful not to oversell this process. Medicine is never going to be an exact science and we are never going to have exact protocols for every situation. A cookbook would not be good for patients or doctors. We can probably do a better job in telling the patient with a headache that he can't have a CAT scan, but to do that we need tort reform.

PAUL VON EBERS—One of the things that came out of this national election was that there appears to be more willingness in the electorate to sacrifice to make things work. The budget deficit was the issue that was discussed most often in the election and I believe it applies to health care. We need to educate people about the fact that everyone has to give up something in order to get a system that works. I think the public is ready to accept that. We don't have that climate right now and without tort reform we aren't going to get it.

ELAINE SZYMONIAK—There's going to be a tremendous resistance to tort reform as there always has been. I think the way to come at it is with some kind of compromise. I just would be real careful about getting into a legislative battle on that issue.

DR. TRIMBLE—There is room to explore alternative dispute resolutions and alternative compensation proposals, but that can't be a total alternative to tort reform.

DR. ALBERTS—When you've spoken to lay groups, has anyone shown intense interest?

PAUL VON EBERS—This probably won't be a surprise to your audience but the person who comes up and says they want to be involved is usually a physician. People who have no contact with health care in their daily lives are interested but I think they feel somewhat powerless.

Dr. Alberts—If people hear a physician talk about health care reform, they go away saying physicians are self-serving. The same is true for someone from the insurance industry.

PAUL VON EBERS—I think there is a recognition that the insurance system, whether it's publicly or privately run, is not enough. The infant mortality rate in Des Moines is a great example. We have medical facilities in close proximity to low income populations. Those facilities are not turning people away, yet we have a high infant mortality rate. That says there is a need for educational and direct service delivery outreach to those communities. Insurance systems don't do that. It's good to get people covered so they can go into a hospital, but that's not going to solve all the health problems and we have not focused on the linkage between the insurance system and the public health system.

Dr. Eversmann—I would like to comment on a point you made just a minute ago, Dr. Alberts. I agree that the public believes anything a physician says about health care reform is self-serving, but I take exception to this. Many of us commit ourselves to medical practice because we feel a responsibility to the people of this state and we are not discussing health care reform purely for the protection of our own assets. We are discussing it in order to improve delivery of health care to individual patients. We cannot defend our incomes, I'm not suggesting we should, but we can do our best to ensure that patients and physicians can live with whatever reforms are put in place.

ELAINE SZYMONIAK—What's happened that the public doesn't believe that? They still respect doctors but they are so ready to criticize and to sue. I think we have expected too much of doctors. Some responsibility has to belong to the public, some leadership has to come from other sectors such as insurance companies.

DR. TRIMBLE—I think physicians have to remain clearly focused on gaining access to health care for those who are denied access and to facilitate patient-focused health care. We must avoid being diverted by issues that relate to income. Society has suggested that medicine should be market oriented. Maybe that wasn't given a fair try but the emphasis

of a market orientation is making money. I think there have been doctors, hospitals and entrepreneurs who lost sight of the other goals in medicine.

CHRIS ATCHISON—We live in an age of cynicism. Insurance companies are a problem, government is a problem, physicians are a

'Unless we do adopt a more optimistic visionary view of what we want to achieve, we aren't going to achieve it because people won't leave sacred cows at the door.'





problem, everybody is a problem, it's always the other guy who's a problem. I think Governor Clinton has begun to speak about having a collective vision of what we need to achieve. I don't think physicians by themselves are going to be able to address the cynicism about them unless we address the cynicism in society. Unless we do adopt a more optimistic visionary view of what we want to achieve, we aren't going to achieve it because people won't leave sacred cows at the door. We aren't focusing on solving problems because we're spending too much time in simplistic attacks on the other guy's motive. President-elect Clinton has said some things rhetorically that I really hope will influence the next generations of public policy makers.

PAUL VON EBERS—It's no mistake that Governor Clinton beat up on insurance companies throughout his campaign because we were an easy target and were viewed as one of the bad guys. Speaking from the insurance industry side, I think it's important for us to re-establish a sense with the public that we're on their side. That means we have to be out in front saying yes you're right, the insurance system has not been working, we have been focusing on the wrong things. That doesn't mean we have to give up our viability as organizations. That doesn't mean we have to scrap the health insurance system, but it does

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'People have to realize that health care reform will be a series of tradeoffs'

Bruce Trimble, M.D.

mean we acknowledge where we haven't been as helpful and make an effort to do that. I don't think physicians have to take the whole problem on the backs of their incomes. I think a lot of the physicians in Iowa are not highly paid. We have a real problem attracting primary care physicians and doctors in Iowa have been among the lowest paid in the country. But I think doctors could move

out into the forefront of telling the public, OK we understand you're concerned about cost and we're going to do everything we can to help you.

ELAINE SZYMONIAK—Government has contributed to the current cynicism by always trying to legislate to cover the worse possibilities.

PAUL VON EBERS—I've been working with the ILC for two years and I think that the group has done a lot of good work. There is a basis for continued work toward health care reform. Obviously, we haven't satisfied everybody's concerns yet. Certainly physicians have a lot of concerns about how the ILC would work with regard to physicians and there is concern about the increasing growth of technology and consumer demand, how that will play out in a controlled expenditure environment and how that would affect physicians. The tort reform issue also needs some additional work. We've also had some concerns from small business about the

Health care reform bill will be introduced early, says Iowa adviser to Clinton campaign

Some type of comprehensive plan for reforming America's health care system will be introduced in Congress within 100 days of President-elect Clinton's inauguration, says Dr. Stephen Gleason, a Des Moines physician who is a national health adviser for Bill Clinton.

Though many of the details have yet to be decided, Bill Clinton "emerged from this campaign with a clear mandate for changing the system," according to Dr. Gleason.

Clinton staff has begun working on a bill, and, at press time, Dr. Gleason was waiting to learn if he would play a role in drafting the exact language of the bill.

Dr. Gleason said Clinton's plan will be an "employment-based, private system with no payroll tax," a requirement that employers buy insurance for employees and an all payor employer purchasing pool similar to the one proposed by the lowa Leadership Consortium. This pool, explains Dr. Gleason, would "fold in the Medicaid population, the unemployed and the uninsured."

"Bill Clinton has never advocated a single payor plan, and this will not be a program like the ones in England or Canada," Dr. Gleason adds.

There has been much speculation since the election regarding how much freedom individual states will have in enacting health care reform. Dr. Gleason says any plan enacted by a state "will have to fit Clinton's national plan."

"If we don't pass a national bill, the states would probably be more likely to get their waivers," he adds.

Dr. Gleason said Clinton advisors feel they have a "friendly Congress" in the area of health care reform and that a Clinton plan would be fairly well-received, though not without points of contention.

Dr. Gleason also says much work must be done to educate the public and that "Bill Clinton and his senior staff have made a commitment to work with physicians" on health care reform.

financing mechanism and we've begun to take some steps to respond to those. I have real concerns about how some of the managed competition plans would work in rural Iowa, but I think we've got a start.

ELAINE SZYMONIAK—I look at proposals from the legislative viewpoint, always thinking about what the opposition is going to be. Legislators don't like to be involved in controversial things if there is another way. It's hard to get anything passed, hard even to get it out of committee, if there are people working strongly against it. I have said we need to try to approach consensus. I don't think we're at all ready to do anything in the legislature because we aren't educated enough about possible solutions.

CHRIS ATCHISON—One of the things we haven't discussed is administrative reform. I think we need some type of electronic benefit payment system. There is an effort already underway in Iowa called the CHMIS (Community Health Management Information System) which would be an electronic fund transfer program. Presumably, all health facilities including physicians' offices would be tied into it. I think it's consistent with the electronic bill processing endorsed by the IMS. Physicians and practices are going to have to prepare for this kind of a change.

DR. TRIMBLE—I think the ILC has been an excellent process. We hash through our ap-

proaches. I have changed my ideas and I assume others have, too. I think within that ILC framework there is potentially a plan that I and perhaps the IMS could support. There are a lot of specifics to be worked out. Physicians are going to insist that we see a lot of details because whatever plan we adopt we're going to have to live with patient by patient, day by day. I hope that at the end of that process there will be a plan that constituents around the state including physicians will support.

Dr. Eversmann—I believe health care reform in Iowa will include some sort of commission. The less this commission resembles HCFA, the better it will work and the more acceptable it will be to physicians. Without controls on patient demand and liability reform, spending caps will simply lead to overuse and deterioration of the health care system. A single claim form and electronic billing would be cost saving. Risk sharing and risk adjustments are certainly important from the standpoint of improving access and affordability. A basic health care policy is essential. Studies on how practices deliver service are less threatening and may be more valuable in the long run from the standpoint of cost control and practice management. In conclusion, I want to emphasize that the public and all of us working in this area need to keep our perspective about what will be best for Iowans.

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Without mandate to president, health care reform left to Congress

The American public has not given the newly-elected president a clear mandate on health care reform, says Fred Grandy, 6th District Congressman from lowa.

Congressman Fred Grandy

Washington, D.C.

IN NOVEMBER OF 1991 following the election of Bob Wofford (D-PA) to the U.S. Senate, it appeared health care reform would be "the" deciding issue in the presidential election. It now appears the American public has not provided the president with a mandate to move forward with a specific health care reform agenda. Barring such a voter mandate, Congress is left to craft a health care reform program with whoever is in the White House.

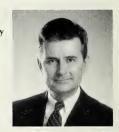
Congress has obviously been extremely active in developing comprehensive health care reform proposals. There are three broad reform initiatives being pursued at the federal level: the single-payor approach, the play-or-pay approach and the market based approach.

The single-payor approach would replace the pluralistic system of multiple insurers, self-insured companies, hospitals, providers, medical equipment suppliers and pharmaceutical companies that exist today with a government controlled system. Basically, the single-payor approach would provide a Medicare like benefit for all Americans.

Government determines expenditures

Under a play-or-pay approach, companies would be required to offer and contribute to employee health care coverage or pay into a

Fred Grandy



government fund which would provide health insurance coverage to individuals not receiving coverage through their employers or who are unemployed. This approach would provide global budgets which health care providers would be forced to meet on an annual basis. In effect, the government would determine the amount of money the country would spend on health care for a given year.

The market based approach builds upon the strengths of the U.S. health care system while correcting clear and obvious problems within the system. The market approach would enact comprehensive reforms aimed at leveling the health insurance market playing field between small and large companies through reforms of the small group insurance market.

This approach would also provide for changes to the medical malpractice system and administrative and paperwork simplification provisions which would free up money currently wasted in the system. The market approach would provide equal treatment

among purchasers of health insurance by expanding to 100% the deductibility of health insurance premium expenses for the self-employed.

Is there a consensus?

It has been widely argued that there is no consensus on which approach the federal government should pursue. However, there is broad agreement on several reform provisions that I believe could be enacted relatively quickly. With the introduction of the Conservative Democratic Forum's (CDF) health care reform proposal—"The Managed Care Act of 1992"—there appears to be a growing consensus in the direction of federal health care reform. The CDF is a group of nearly 60 conservative and moderate Democrat members of the House led by Rep. Stenholm.

The CDF proposal contains many provisions similar to the small group market reform proposals introduced by Senator Bentsen and Rep. Rostenkowski. It is very similar to the House Leader Task Force on Health proposal (Action Now), the Senate Republicans (Chafee Task Force) proposal and President Bush's health care reform proposal.

While this seems promising, it is important to recognize that several powerful committee chairmen and members are opposed to reform of the current system. Clearly, if you believe the current system is unfixable, as many of these members do, initiatives aimed at improving that system would only delay a total overhaul.

Government struggles, states move

As the federal government struggles to develop a consensus on which health care reform approach to pursue, states saddled with budget problems are attempting to move forward with various initiatives to address the health care crisis.

This begs the question of: barring federal reform, how much progress can state governments make in their attempts to accomplish reforms at the state level?

States have been very active on this front, developing various initiatives to address portions of the health care equation, establishing pilot projects and efforts at comprehensive reforms. Approaches to health care reform at the state level include: risk pools for uninsurables, programs funded by earmarked taxes, employer mandates, tax credits

to subsidize expansion of employer-provided insurance coverage, small group market reform, rationing and other innovative reforms both comprehensive and incremental.

As states move forward with these proposals, they find their proposals at odds with federal programs and regulations. One focus of state-based health reform has been Medicaid waivers and how much liberty states have in developing their own programs for the medically indigent within their state—while continuing to receive federal matching funds.

Another focus has been on how the Employee Retirement Income Security Act (ERISA) relates to their proposed state-based health reform initiatives.

Waiver interest 'vague and undirected'

While there is great interest in state-level health care reform, for the most part this interest has been expressed in vague and undirected terms. Simply saying that the waiver process needs to be facilitated and streamlined is only the first level of debate. Because there are different types of waivers and different levels of change, states need to be more clear about what exactly they intend to change.

The House Wednesday Group has created a State Initiatives Task Force (of which I am a member) to address various policy options available to eliminate these conflicts. Before any changes are made, the Task Force will review a number of issues which must be addressed. These include: What level of flexibility beyond that which is currently available in the Medicaid program should be allowed? Should change occur within the current Medicaid waiver process or through an entirely new process? What amount of federal oversight will be needed for these reform initiatives? How will federal matching funds be affected? Should states be allowed to experiment with the current employer-based health insurance system as protected under ERISA? If any type of ERISA reform is contemplated, how will new state regulations affect existing employer plans?

The end result of the state experiments needs to be determined or, at the very least, there should be an awareness that there are different desired outcomes for this reform approach.

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Physicians must guide allocation of medical resources

Society can no longer have it all. Physicians must learn how to reconcile their dedication to quality care with the obvious need to cut costs, says our guest author, a member of the IMS Committee on Health Care Reform.

Louis Rodgers, M.D.

Des Moines, Iowa

IIT T WAS THE BEST OF times; it was the ▲worst of times." So began a classic Dickens novel set in the turbulent and uncertain time of the French revolution. These are also the best of times in American medicine. Training and expertise of physicians, technological advancements, and development of problem specific pharmaceuticals have brought us to the pinnacle of modern medical care. These are the worst of times for the 30% of our population whose access to that medical care is limited or nonexistent. The burden of cost shifting on the remaining 70% is stressing our national economy. A time for revolution? A time to dismantle what we have and begin again? I think not. It is, however, a time for reform. We need to, and we must, re-structure our health care system. Thankfully, we can be a part of the reformation process if we present the proper leadership and workable plans. No one understands the system better than the medical professionals, and no one can possibly understand the medical needs of the population nearly as well.

To control health care costs, the business community and insurance industry have re-

Louis Rodgers, M.D.



acted remarkably like our federal government by resorting to regulations and the attendant layering of bureaucracy and inflation of costs. Management policies that keep the patient separated from the physician may temporarily reduce costs but are ultimately detrimental to the quality of the patient's health care. Meanwhile, costs continue to escalate. What we have learned thus far, or should have learned, is that the business and government policymakers insulate themselves from the clinics and sickrooms. They have made it our job to police and enforce the regulatory policies, oftentimes contrary to our professional judgment.

To this point, the strength of our position in society has been earned because we

(Continued next page)

have been, and society knows we have been, primarily dedicated to our patients' welfare. We have been our patients' advocates. In our pursuit for the very best care possible, we have not always considered costs. That is understandable. We make our decisions at the bedside or encircled by family members in a waiting room, being advised to "do everything possible" and "cost is no object." Life is precious and cannot be expressed in dollars. We still cannot disagree with these thoughts and expressions that flow from the stressed patients and family members. Others do, however, and we must appreciate their point of view.

As patient advocates, how can we reconcile our dedication to quality care for our patients with budgeting our resources for care? We may say that ethically we cannot. Government and business leaders say they can and they will, and have no emotional conflicts with their decision-making. If we accept the premise that we are best equipped to understand the system and the patient's need, then we should guide the decisions regarding how resources are applied to medical care needs

and expenditures.

In the formulation of the bold and controversial Oregon Medicaid plan, five physicians served on an 11-member commission that prioritized 709 items of health services, ranking these items from most to least important. The legislature then budgeted coverage through Item 587 but by prior agreement was not allowed to alter the list. Making "the cut" were liver transplants for children with biliary atresia but not for patients with alcoholic cirrhosis. Heart bypasses were approved, as were AZT and other treatments for opportunistic infections of HIV disease. Aggressive treatment of extremely premature babies was denied. Words like "aggressive" and "extremely" will, of course, be debated, but the commission of five physicians, four consumers, a public health nurse and a social worker did their job of prioritization. Lawmakers funded what the budget would allow. While 83% of the health problems met approval for payment, Oregon law stated that the other 17% of problems did not merit reimbursement for care. The plan is now in a holding pattern.

If we are to escape the label of "medical entrepreneur" and maintain the distinguished title of physician, we must now contribute in a way that will be strange and foreign to us. To do otherwise is to abandon our patients as callously as walking away when someone's blood pressure is 50/0.

Ethically, we have to sort the necessary from the unnecessary and the important from the unimportant, but first we must understand clearly that society in general cannot any longer have it all. If we do otherwise, we will have a system restructured by the unknowing for the unsuspecting, and our reward will be frustration and despair.

We may not need to emulate the Oregon plan, perhaps no state or nation does, but we should learn an important lesson from their work. Leave medical decisions to people educated, trained and experienced in medical matters and leave economic decisions to the

people managing the budget.

If necessary, do we have, among Iowa's nearly 4,000 physicians, five who will step forward to do the job? These five could rightly quote from the ending of the Dickens classic, "It is a far, far better thing that I do than I have ever done." That is assuming the guillotine remains illegal.



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Women

This retired surgeon, a member of the IMS Editorial Board, asks a timely question: Do male physicians really understand their women patients?

Daniel Crowley, M.D.

Des Moines

WHAT FOLLOWS IS for men only. Brothers—let us begin with a quotation: "The great question . . . which I have not been able to answer, despite my thirty years of research into the feminine soul, is 'What does a woman want?'"

Who said that? It was said by one of the greatest doctors in the history of medicine—

Sigmund Freud.

Perhaps Freud, involved with his egos, superegos and ids, didn't understand women. Fortunately, you and I are not so encumbered, and can look at the matter with our well-known objectivity. We understand women.

Now, for your enlightenment, read an article in the Winter, 1991 issue of *The Pharos* (journal of Alpha Omega Alpha) entitled "Scoot down to the edge of the table, hon," with the subtitle: "Women's medical experiences portrayed in literature"—an article written by women, about literature written by women, concerning four health issues uniquely important to women: breast cancer, hysterectomy, childbirth, and miscarriage/abortion.

The authors, Delese Wear, Ph.D. and Lois LaCivita Nixon, Ph.D., believe that literature (fiction and poetry) frequently expresses reality better than the usual clinical case report, and, in so doing, permits better understanding by physicians of women's emotions and concerns in these matters.

That having been said, it is time to mention, briefly, selections extracted from the article, bearing in mind that all quotations are from the article and/or the literature being discussed, and represent the words and viewpoints of women writers concerning the health issues in question.

Breast cancer: referring to a mastectomy with "the horror, fear and humiliation of a

sliced-off breast."

Hysterectomy: telling of a woman's dismay and "so great a shock that you believe you cannot bear to live with it" when, following a hysterectomy, the patient realizes that she now has a "dead end" vagina.

Childbirth: telling of a pregnant woman's "chagrin" because "pregnancy ... puts a woman in the public domain ... permits no secrets ... everyone knows how you got that way ... still and again the victim of patroniz-

ing humor clearly not funny."

Abortion: describing "the contemporary abortion as having 'entered the age of the assembly line'"; quoting from Alice Walker's story "The Abortion": "Somewhere her child—she never dodged into the language of 'fetuses' and 'amorphous growths'—was being flushed down a sewer, gone all her or his chances to see the sunlight, savor a fig"; referring to Lucille Clifton's "the lost baby poem": telling of "a mother talking sometime later to an unborn child she aborted . . referring to 'your almost body' which she dropped 'to meet the waters under the city/ and run one with the sewage to the sea.' "

(Continued next page)

But what of another problem of women so far not mentioned—specifically, their problem with men?

The October, 1991 issue of *Esquire* brings some insight into the "problem" of men as seen by women. The article—by title "Pigs, dudes, Slimeballs, victims, Studs, wimps, Girl toys, fools, Heroes, Human beings?"—tells, in a series of essays, what 18 prominent women think of men.

It is impossible to summarize or generalize about the opinions expressed in the 18 essays, but the epithets in the title are suggestive.

If men were to pick out a favorite among the essays, I believe it would doubtless be that written by Erica Jong. She believes that "A world of women, or of womanish men, is as terrifying as a world of man-eating Amazons. For all the faults, we still need the spice of opposite sexes to create a vital society—long live masculinity."

So, brothers, put aside the epithets, and forget Sigmund Freud. Let us end on a high note, echoing Erica Jong with an enthusiastic reciprocal toast—Long live femininity!



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ASIM offers updated "Stop Smoking" kit

THE AMERICAN SOCIETY of Internal Medicine (ASIM) has updated its "Stop Smoking Campaign Kit for Physicians" to encourage them to 1) create a smoke-free office; 2) counsel smoking patients to quit; and 3) be role models for patients by quitting themselves

Kit materials include: tips for establishing a "no smoking" office policy; a distinctively illustrated poster and table-top display card telling patients, "When it Comes to Good Health, Don't Let Yours Go Up in Smokel"; a lapel pin with the "no smoking" symbol; a list of magazines for reception areas that *do not* contain tobacco advertisements; a ready-to-copy fact sheet with the latest health statistics on tobacco use; an index of up-to-date, informative articles on smoking cessation; and a compilation of patient and physician education materials and office aids available from other organizations.

To order ASIM's "Stop Smoking Campaign Kit for Physicians," send a check for \$9 to the American Society of Internal Medicine, Literature Order Dept., NR, 2011 Pennsylvania Avenue, NW, Suite 800, Washington, D.C. 20006-1808. ASIM members receive a

20% discount.

Seek medical equipment, supplies

Physicians for social responsibility (PSR) is attempting to consolidate some of the medical relief efforts for the former Soviet Union.

PSR historically has been concerned with the inherent dangers of nuclear weapons, but the ending of the Cold War hasn't changed those dangers. PSR is initiating an effort to identify, collect and prepare for shipment used medical supplies and equipment that have been captured from normal disposal routes.

Virtually any and all medical supplies can be potentials for salvage provided they are: unused or unexpired surplus no longer in use by the institution; opened, but unused and uncontaminated; used and capable of being reprocessed; or unused and expired but capable of being reprocessed.

Common items to be captured include gloves, sutures, sponges, pads, tape, ban-

dages, scalpel, syringes, etc.

PSR organizers say any electrical or mechanical equipment can be recycled and sent to the former Soviet Union.

A former Iowa resident and medical school graduate Monk Elmer, M.D., is available to answer questions regarding the PSR campaign to aid the Soviet Union. Dr. Elmer's address is: 1020 N. Appleton Road, Appleton, Wisconsin, 54911. His office phone number is 414/788-6301.

In addition, Iowa Yucatan Partners of the Americas is seeking a donation of a fiberoptic flexible colonoscope to be used in a clinic that serves poor people in the Yucatan Peninsula of Mexico. Contact Cyndi Ringgenberg, R.N., Iowa Yucatan Partners health chairman, 2323 290th St, Kelley, Iowa 50134, telephone 515/769-2458.

College of Medicine Highlights

THE FIRST CLINICAL TRIALS OF A BLOOD SUBSTITUTE in humans will begin this summer. Joseph Walder, biochemistry, developed the substitute, which has been licensed by the UI Research Foundation to Baxter International Inc. Baxter will conduct human trials in the U.S. and Europe over the next several years. The substitute, intended for emergency transfusions, uses modified hemoglobin from outdated blood supplies and is free of viruses, compatible with any blood type and has a shelf life of over one year.

CHANGES IN ASTHMA TREATMENT ARE RECOMMENDED. Dr. Thomas Casale, internal medicine, urges physicians to treat asthma as a chronic, persistent inflammation of the lung's airways, rather than as isolated episodes of muscle spasms. Casale is a member of the Asthma Technical Advisory Group of the American Lung Association.

A NEW TREATMENT FOR MALE INFER-TILITY was presented by Dr. James Dono-

(Continued next page)

van, Jr., urology, to the American Urological Association in Washington, D.C. Donovan uses laparoscopic surgery to perform varix ligation of dilated spermatic veins to treat male infertility. Dilated spermatic veins may fail to return blood to the heart and instead direct it to the testicles, causing infertility.

THE UI WILL LEAD A FIVE-YEAR HEALTH CARE ASSESSMENT. Dr. Charles Helms, internal medicine, and Dr. Douglas Wakefield, hospital and health administration, received a \$985,000 endowment from the Robert Wood Johnson Foundation to continue their health care assessment project with 12 lowa hospitals under the Iowa Hospital Quality Assessment and Enhancement Institute.

ROUTINE HYSTERECTOMIES MAY NOT BE WARRANTED for women with benign tumors, especially when there are no symptoms or discomfort. Dr. Robert Reiter, obstetrics and gynecology, directed the study which found that the potential risks posed by hysterectomies outweigh the risks posed by tumors, even when the uterus is larger than that of a 12-week pregnancy.

FAMILY PLANNING SAVES TAX DOL-LARS, according to a study commissioned by the Family Planning Council of Iowa. Dr. Peter Hilsenrath, hospital and health administration, found that for every dollar spent on family planning services, Iowa taxpayers saved \$8 to \$15 in costs for tax-supported services for unintended pregnancies and births among low-income women.

A DRUG TO PREVENT OSTEOPOROSIS is being tested in fracture intervention trials conducted by Dr. James Torner and Dr. Robert Wallace, both in preventive medicine and environmental health. The drug, developed by Merck Sharp & Dohme Research Laboratories, is not a hormone. Says Torner, it "may prevent osteoporosis, increase the amount of healthy bone and prevent fractures in older women." The UI and 11 other institutions are participating in the study that will involve 6,600 women.

CANCER RATES ARE HIGHER AMONG URBAN IOWA RESIDENTS than those in rural areas, according to the 1992 UI State

Health Registry report. **Dr. Charles Lynch, preventive medicine,** said the excess cancers in urban residents are smoking related. The National Cancer Center and other research organizations fund the State Registry of Iowa, which tracks more than 97% of the 250,000 Iowans diagnosed with cancers since 1973.

"HYPERLUNG," AN ELECTRONIC TEXT-BOOK developed by the Department of Radiology, combines text, video clips of lab procedures and "walking and talking" instructors lecturing on lung disease. Dr. Jeff Galvin, radiology, supplied the medical knowledge in the computerized textbook. Dr. William Erkonen, radiology, noted a study showing significantly higher retention of information in students using the interactive electronic textbooks versus those receiving only verbal instruction in lectures.

THE UI TRAINS FAMILY PHYSICIANS TO CARE FOR HIV PATIENTS in response to the growing numbers of people infected with the virus in smaller and rural communities. Dr. Ralph Knudson, family practice, directs the three-year project that matches family practice residents with HIV-positive patients. By following the HIV patient over several years, residents learn all facets of the disease.

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Holiday Greetings

Warmest thoughts

and best wishes

to you and your family

this holiday season.

The Iowa Medical Society Auxiliary

Iowa breast and cervical cancer project

It is estimated 2,300 Iowa women will be diagnosed with breast cancer in 1992; 600 will die.

The Iowa Department of Public Health is pursuing a reduction in breast and cervical cancer through a county pilot project and development of an in-depth prevention pro-

gram.

The pilot project, funded by a Blue Cross/Blue Shield of Iowa foundation, will take place in Van Buren County and will consist of educational, screening and surveillance systems. Methods used will include self-examination, clinical physical examination, mammography and the Pap test.

The statewide Breast and Cervical Cancer Control Project proposal, being developed for submission to the Centers for Disease Control, includes coalition development, public and professional education, surveillance screening and follow up, quality assurance

programs and evaluation.

Nationally, cancer objectives have been identified for completion by the year 2000 and focus on areas of prevention and detection with the greatest potential for reducing new cases of cancer, morbidity and mortality. The state's plan, called Healthy Iowans 2000, includes the following cancer-related goals:

• Increase to at least 80% the proportion of Iowa women aged 40 and older who have received a clinical breast examination and a mammogram and increase to at least 60% those aged 50 and older who have received them within the preceding one to two years.

 Increase to 100% the proportion of facilities in Iowa performing mammography that are certified by a private organization or that meet specific state and federal rules regarding specific quality standards.

• Increase to at least 95% the proportion of women aged 18 and older with an intact

uterine cervix who have received a Papanicolaou (Pap) test and to at least 85% those who have received a Pap test within the preceding one to three years.

 Ensure that Pap tests meet quality standards by monitoring and certifying all cytol-

ogy laboratories by 1994.

Breast cancer is the most common form of cancer in women, with one of every nine females developing it. Women 50 years and older are particularly at risk. Nationally, black women younger than 50 years have a slightly higher mortality rate than do white women.

Three secondary prevention modalities have been offered as tools in the fight against breast cancer: breast self-examination, breast clinical examination by a trained health professional and mammography. Numerous studies have demonstrated that mammography and breast clinical examination are both underutilized. This underutilization appears to be most severe among certain sociodemographic groups — the elderly, the socioeconomically disadvantaged, rural populations and racial and ethnic minorities. Clearly, if society is to make progress in reducing morbidity and mortality from breast cancer, these underserved populations will require increased knowledge, better access to health care and more screening.

Multiple studies have indicated that women obtain mammograms based on the advice of their physicians. This appears to be true regardless of a woman's sociodemographic background and is particularly true

for elderly women.

Education by a physician, other health professional or a lay volunteer could improve compliance with preventive guidelines. However, this individual-directed process may require multiple sessions or repetitive counseling before women undertake the desired action.

This article was written by Jane Schadle, IDPH.



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Partial thoracic aortic occlusion in blunt trauma

As illustrated by this case report, partial thoracic aortic occlusion is a peculiar injury. The author questions the significance of the vascular compromise and reviews Poiseuille's Law. Similar injuries may have gone undiscovered prior to CT and MRI scanning.

Dennis Leland, M.D.

RUPTURE OF THE THORACIC AORTA is a known complication of blunt trauma, while occlusion is more often noted in the abdominal aorta. This is a case report of partial occlusion of the thoracic aorta, associated with spinal fracture, after blunt chest trauma sustained in an automobile accident. Though it is probable injuries of this nature have occurred in the past, none are reported in the literature.

Case Report

A 67-year-old obese female was the driver of an auto struck on the driver's side by another auto at a high rate of speed. No loss of consciousness or abnormal neurological findings were noted at the scene. The patient was transported to the emergency room on a backboard and with a cervical collar.

She complained of numbness in her feet, although no motor losses were noted. She had a Glascow coma scale score of 15 and vital signs

were: pulse—102, heart rate—111, respiratory rate—20 and a systolic blood pressure—70.

Within five minutes of arrival she could not move her feet or legs. No clear sensory level loss could be identified. Twenty minutes later she had a clear T₈-T₆ sensory level and no leg movement; her neurological exam was otherwise normal. All pulses were intact and palpable and the remainder of the exam was unremarkable. Laboratory studies were noncontributory. X-ray studies showed multiple rightsided rib fractures and a comminuted fracture of the left distal fibula. Lateral thoracic and lumbar films were obtained but were inconclusive. The radiologist reported, "I could not exclude fracture on the basis of this film."

The initial treatment included IV solumedrol, antibiotics, tetanus toxoid and crystalloid fluid resuscitation. A nasogastric tube, Foley catheter and arterial line were placed in addition to two large bore IVs. The ankle fracture was reduced and splinted in the emergency room.

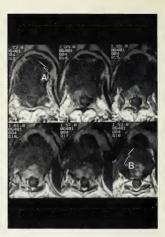
CT and MRI scans of the thoracic spine were obtained. These revealed a fracture dislocation of the T₁₀ vertebral body with distraction of the posterior elements (Figures 1, 2). Spinal

When this paper was written, Dr. Leland was a surgery resident at Veterans Administration Medical Center in Des Moines. He has since relocated to Mitchell, South Dakota.

THE IMS EDUCATION FUND HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION AWARD FOR DECEMBER 1992







Figures 1 and 2. Sagittal views illustrating a fracture of T_{10} with anterior displacement of inferior structures and compression of the thoracic aorta.

Figure 3. Coronal views show marked compression of the aorta in the AP diameter (A) and its normal diameter distal to the obstruction (B).

cord transection was noted as was compression of the aorta in the AP diameter, estimated at greater than 80% (Figure 3).

The arm ankle Doppler index was 0.97 on the right. The left side could not be examined because of a cast but the "phasicity" at the common femoral and popliteal arteries was normal. The vascular surgery service evaluated the patient and recommended heparinization but no further vascular intervention; these recommendations were followed.

The patient had early stabilization and fusion with a $T_{\rm T}L_1$ Harrington rod placement. She subsequently had a prolonged hospitalization with numerous complications including respiratory failure and ventilator dependency, wound infection of the back, and a pulmonary embolus necessitating Greenfield filter placement. She eventually succumbed to multi-system organ failure. An autopsy was denied by the patient's family.

Discussion

This case represents a rare combination in aortic injury. First, aortic occlusion is usually associated with the abdominal aorta and only rarely is partial occlusion found except in intimal tears and flaps. Second, thoracic aortic injuries are usually full-thickness tears or disruptions

as opposed to stenosis or partial occlusion. This fact is related to the vulnerable points of aortic fixation in the chest—these being (a) ascending aorta at the heart, (b) attachment of ligamentum arteriosum and (c) diaphragm.^{1,2}

This case illustrated an aortic occlusion which was not in the abdomen and a thoracic aortic injury which was not a tear or disruption. No similar case reports were found in a review of the literature.

This particular case raised the question of namely how this partial occlusion would affect flow to the more distal structures. It is known from Poiseuille's Law that energy losses associated with arterial lesions are inversely proportional to the fourth power of the difference between the radius of the non stenotic and stenotic segments.³

This law, applied to the concept of critical stenosis, suggests any lesion which compromises the arterial lumen by about 75% could cause significant decrease in flow. This raised concerns about distal perfusion in the case presented, especially the abdominal viscera. In this case, however, pressure and Doppler studies showed no measurable lack of flow distal to the stenotic area despite an occlusion of the thoracic aorta in excess of 80%.

Although the need for therapeutic heparinization in this case could be disputed, it was felt that the morbidity of total aortic occlusion from clot formation would be so devastating compared to the relative risks associated with heparin that anticoagulation therapy was administered until just before reduction and fixation of the spinal fracture. Reduction of the fracture removed the extrinsic aortic compression and the aorta returned to its normal diameter.

Had this patient been treated before the advent of CT and MRI imaging, it is likely the compressive findings in the aorta would have gone unnoticed, especially since she had no symptoms of vascular compromise distal to the occlusive segment. Further, even if the problems could have been recognized, the need for therapeutic intervention would undoubtedly be controversial.

Because of the rare nature of the injury, it is unlikely these questions will be answered soon. Still, when discovering a stenotic area,

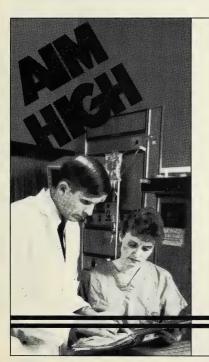
especially when there is a potentially significant or critical stenosis, it would be difficult for most physicians to not intervene.

Summary

This case raises some interesting points. First, it allows a review of Poiseuille's Law and its application to vascular disease. It raises the question of whether or not some CT and MRI findings are of clinical significance. Finally, one must question whether or not intervention is indicated based on these "high tech" findings. Only the passage of time and accumulation of further data will give us the correct answers.

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Attending physicians must personally evaluate patients

Editor's Note: As part of the PRO contract with the Health Care Financing Administration (HCFA), the Iowa Foundation for Medical Care (IFMC) reviews care provided to Medicare beneficiaries in acute hospital settings.

The following case illustrates a situation in which the attending physician never personally

evaluated the patient.

A 68-YEAR-OLD FEMALE WAS admitted to the emergency room (ER) from the nursing home on November 6 at 4:30 P.M. She had a temperature of 39.5°C, chills, vomiting, diarrhea and abdominal pain. Laboratory work at the time of admission showed a creatinine of 1.6 (normal 0.5-1.4), BUN of 22 (normal 6-22), a WBC of 19.8, and a urinalysis showing 10-15 WBC, positive ketones and 2+ bacteria. Initial arterial blood gases revealed a pH of 7.51, a pCO2 of 27 and a pO2 of 57.

At 7:30 P.M., the patient was admitted from the ER. Admission orders were written by the ER physician providing IV fluids, antibiotics and pain medications. The ER physician notified the attending physician's office of the patient's acute distress, indicating that the attending physician should follow up with the patient as soon as possible. At midnight and again at 2:45 A.M. on November 7, nursing staff attempted to contact Dr. Jones by telephone. Dr. Doe, the attending physician's partner, returned the call at 3:10 A.M. and was informed of the patient's worsening condition. No orders were received at that time. When the patient's condition began to further deteriorate, Dr. Doe was again notified at 4:15 A.M. Orders were received to call

Dr. Greene, another partner of the attending physician, to see the patient.

At 5:15 A.M., the patient's respirations were 40 per minute and her skin was pale and moist. The nursing supervisor paged Dr. Smith, the on-call physician, to see the pa-

'It was inappropriate to provide telephone orders to treat the patient, even more so to expect other physicians to supervise the patient's care.'

tient at 5:40 A.M. When Dr. Smith arrived, the patient was pulseless and breathless. The patient was pronounced dead at 6:05 A.M.

Reviewer comments

According to the documentation in the medical record, the patient was not seen by the attending physician from the time she was transferred from the ER at 7:30 P.M. on November 6 until she died on November 7.

The patient was admitted under Dr. Jones and should have been personally assessed by him following admission from the ER. It was inappropriate to provide telephone orders to treat the patient, even more so to expect other physicians to supervise the patient's care. Failure to examine and treat this patient in a timely manner placed the patient in imminent danger and resulted in the failure to recognize and effectively treat the patient's worsening septic condition.

This case was assigned a severity level III: Confirmed quality problem with significant adverse effect(s) on the patient.

This article was written by Kevin Quinn, M.D., a Red Oak internist. Dr. Quinn is President of the Iowa Clinical Society of Internal Medicine.

Proof is in the CME pudding

Richard Nelson, M.D.

The rationale for continuing medical education is to improve health care outcomes for patients. There is a broad consensus in the medical community that physicians must continue to learn throughout their careers in order to provide contemporary and effective care.

The principal challenge for CME course directors, preparers of materials and presenters is to utilize a learning mode that not only transmits information, but also results in a change in the practitioner's care of patients.

The presumption of most CME activities is that passive learning (listening to expert lectures or reading) results in professional behavioral change. The behavioral change, in turn, is expected to improve the quality of the health care provided to patients. As care improves, so does the patient's health status or outcome.

The logic of this sequence is compelling, but there has been little evidence that the impact of CME on health care outcomes occurs as presumed. While the foundation of medical education requires the learning of an extraordinary amount of detailed biomedical information, the culmination of that educational process most closely resembles an elaborate apprenticeship. The medical student moves from the classroom to the bedside, acquiring further knowledge and skills from the observation and demonstration of physician mentors.

For too many of us, that learning process concludes—or is vastly diminished—on the day we complete a residency or fellowship and enter practice. Why does this happen? Probably it occurs due to the solitary nature

of medical work. We often consult with colleagues formally and informally, but not from the perspective of being a student.

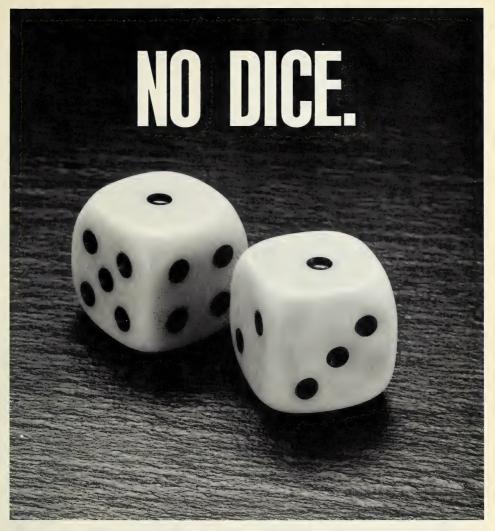
We are more likely to be students in a CME activity. In too many of these activities the learning is sanitized. There are no patients. There is no realistic cognitive process to guide us through the diagnostic or therapeutic maze. Whether our learning predictability leads to improved clinical practice is difficult to measure.

Fortunately, better practice outcomes through CME are not impossible. There is growing evidence that CME learning can have the desired impact. Recently a research group at McMaster University in Hamilton, Ontario reviewed randomized controlled trials to assess the effectiveness of CME (Davis DA et al *JAMA* 268:1111, 1992). They selected studies that included objective assessments of either physician performance or health care outcomes. Of 777 CME studies located by the authors, only 50 met their criteria for inclusion. The majority of the studies measuring physician performance showed positive results in resource utilization, counseling strategies and preventive medicine. Almost one-half of the studies of health care outcomes demonstrated positive changes.

Was there a key to the effectiveness of the successful CME activities? The intensity of the educational effort appeared to be important, especially if the activity had an enabling or reinforcing element. Interactive case discussions, for example, were more effective than activities using a lecture format. A further important tenet was the need for educational objectives in CME activities.

These revelations may not be immediately helpful to CME planners. Yet it might be useful to reinforce that "the proof is in the pudding." All of our CME work may go for naught, unless our patients receive their just desserts.

Dr. Nelson is associate dean for continuing medical education at the University of Iowa College of Medicine.



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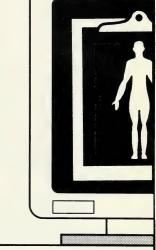
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